AUTHORIZATION FOR RELEASE OF INFORMATION

Section A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations., and that the information released may be subject to re-disclosure by the recipient

Patient Name: _____ SSN#: _____

Phone Number: _____

Persons/organizations providing the information:
_____
_____
_____
_____

Persons/organizations receiving the information:
_____
_____
_____
_____

Specific description of information (including date(s)):
_____
_____

Section B: Must be completed only if a health plan or health care provider has requested the authorization

The health plan or health care provider must complete the following:
* What is the purpose of the disclosure?: _____

* Will the health plan or care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? _____ yes _____ no

The patient or the patient's representative must read and initial the following statements:
* I understand that my health care and the payment for my health care will not be affected if I do not sign this form.
_____ Initials
* I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it. Further, I understand there may be a fee for a copy of this information. _____ Initials

Section C: Must be completed for all authorizations

The patient or the patient's representative must read and initial the following statements:
* I understand that this authorization will expire on _____/_____/_____. _____ Initials

* I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any affect on any actions taken before they received the revocation. _____ Initials

* I understand there will be a fee for copying and releasing my records, and that such fee is in accordance with state and federal guidelines. _____ Initials

* I understand that my records are protected under state and federal law. I understand that specific information to be disclosed may include history of drug or alcohol abuse, mental health treatment, AIDS or any other medical information. _____ Initials

_____ _____
Signature of patient or patient's representative Date
(Form MUST be completed before signing)
Printed name of patient's representative: _____
Relationship to the patient: _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION