Authorization for Release of Protected Health Information

Patient Name: _____Med Rec / Account #_____
Date of Birth: _____

I hereby authorize_____to release information from my medical records to the following entity or persons:
Name: _____
Address: _____
Fax: _____ Email:_____

Please check type of information to be released:

□ Entire Medical Record □ Registration Forms □ Billing / Financial Records
□ Other (Specify) _____

Drug and/or Alcohol Abuse, and/or Mental Health, and/or HIV/AIDS Information Release

Please answer YES or NO to each of the following questions to indicate your permission for us to release the following information (if it is contained in your medical record):

Alcohol & Drug Abuse □YES □NO
Genetic Test Results □YES □NO
Domestic Violence Counseling □YES □NO
HIV/AIDS Test Results □YES □NO
Mental Health Diagnosis/Treatment □YES □NO
Sexual Assault Counseling □YES □NO

I understand that:

- I may withdraw my authorization at any time by submitting a written request to the Privacy Officer. My authorization may be withdrawn except for the following:
  - To the extent that action has been taken in reliance on this authorization.
  - If the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy.
- I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility benefits will not be affected.
- Information released on this authorization, if re-disclosed by the recipient, is no longer protected by Provider.
- This authorization expires: **___ 1 year from date below ___ One time disclosure only ___ Other:_____**

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

Patient's Signature: _____ Date: _____
Print Name:_____(**when patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required).**

Signature of Legal Representative: _____ Date: _____
Print Name of Legal Representative: _____
Description of Legal Representative Authority: □ Parent □ Medical Power of Attorney (attach documentation)
□ Other _____ (Explain and Attach Documentation)

Signature must be verified by Provider staff OR must be notarized. When completed, please place in patient record.

_____	_____	_____
Signature of staff member	**Print Name**	**Date**

SUBSCRIBED AND SWORN before me this _____day of _____, 20_____.
My commission expires:

_____
Notary Public Signature

For Internal Use Only

Information Released/Reviewed By: _____ Date: _____
Clinic/Office: _____

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