Authorization to Release Protected Health Information to a Third Party

Instructions: This form is to be used by a patient or legal representative to authorize the release of information to a third party (other than a family member or friend) such as an insurance company, employer, or for legal purposes, etc. Each section needs to be completed to be valid.

1. Patient Information

Patient Name *(first, middle, last)*

Birth Date *(mm-dd-yyyy)*

2. Release Purpose

Check appropriate box

☐ Continuing care ☐ Disability ☐ Forms completion ☐ Insurance ☐ Legal ☐ Worker's compensation

3. Delivery of Information

Preferred Method

☐ Verbal only

☐ Written copy *(may include completed forms)*

☐ Email address _____

4. Records or Reports to Be Released

Timeframe to Be Released

Date(s)_____ or Year(s)_____
(mm-dd-yyyy) *(yyyy)*

Document/Note(s) (check all that apply)

☐ Behavioral health/Mental/Psychological notes
☐ Operative/Procedure notes
☐ Therapy notes (physical, occupational, speech)
☐ Emergency department/Urgent care notes
☐ Provider notes
☐ Other, specify_____

Additional Records (check all that apply)

☐ Allergy list
☐ Immunizations
☐ Medication list
☐ Billing information for records checked
☐ Laboratory results
☐ HIV lab test results
☐ Genetic testing
☐ Pathology report(s)
☐ EKG(s)/Cardio/Echo
☐ Radiology Report(s)
☐ Radiology image(s), specify exam(s)/body part(s)

Substance Abuse and Addiction Treatment Records (check all that apply)

☐ Assessment/Evaluation
☐ History and physical exam
☐ Multidisciplinary notes
☐ Family participation invitation
☐ Questionnaires
☐ Treatment/Discharge summary
☐ Treatment plans
☐ Other, specify_____

5. Signature and Date

- This authorization may be revoked at any time by providing a written notice of revocation.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal Privacy Law.
- I may request a copy of the signed authorization.
- I have a right to inspect and receive a copy of the material to be disclosed.

Note: A patient (18 years or older) must authorize the release of their own information unless patient is incapacitated or deceased. If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.

Signature (required) ►	**Date (required)** *(mm-dd-yyyy)*