



AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize

NAME OF DISCLOSING PARTY _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

to disclose to

NAME OF RECEIVING PARTY _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

Records and information pertaining to:

NAME OF PATIENT (including other names used) _____ DATE OF BIRTH _____

ADDRESS _____ TELEPHONE NUMBER _____

DURATION: This authorization becomes effective immediately and remains in effect until _____
 or for one year from the date of the signature below. DATE

REVOCATION: This authorization is subject to written revocation by the undersigned, or their personal representative, at any time between now and the disclosure of information by the disclosing party. A written revocation will be effective upon receipt, but will not be effective to the extent that the Requester or others have acted in reliance upon this authorization.

REDISCLASURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or such disclosure is permitted by law.

SPECIFY RECORDS: Sign and date to specify which type of information is to be disclosed:

MEDICAL INFORMATION _____
 SIGNATURE _____ DATE _____

PSYCHIATRIC INFORMATION _____
 SIGNATURE _____ DATE _____

DRUG/ALCOHOL INFORMATION _____
 SIGNATURE _____ DATE _____

HIV BLOOD TEST RESULTS _____
 SIGNATURE _____ DATE _____

OTHER HEALTH INFORMATION (Specify records to be disclosed) _____

The requester may use the health information authorized on this form for the following purpose only:

I may not be required to sign this Authorization as a condition to obtaining treatment or payment or my eligibility for benefits. I am entitled to notice if my protected health information is used for marketing and results in remuneration to the provider.

Signature: _____ Date: _____