

HEALTH INFORMATION DISCLOSURE AUTHORIZATION

This form complies with the HIPAA Privacy Rule

PATIENT INFORMATION

Patient Name: _____ Street Address: _____
(First Name, Middle Initial, Last Name)

City: _____ State: _____ Zip Code: _____ Date of Birth: ____/____/____

SSN: _____ - _____ - _____ Phone #: (____) _____ - _____ Fax #: (____) _____ - _____

REQUESTOR/RECIPIENT INFORMATION (NOTE: ONLY COMPLETE IF THIS SECTION IS DIFFERENT FROM THE ABOVE)

Please disclose the below described protected health information to: _____
(First Name, Middle Initial, Last Name) - OR - Company Name

Street Address: _____ City: _____ State: _____

Zip Code: _____ Phone #: (____) _____ - _____ Fax #: (____) _____ - _____ E-mail: _____

PROTECTED HEALTH INFORMATION ("PHI") TO BE RELEASED

By signing this authorization, I authorize _____ to disclose the below identified PHI.
(Name of office disclosing medical information)

Provide a description of the protected health information to be released (provide a specific description of the information sought, including dates of service): _____

This request is for the purpose of: _____

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy officer of the above named facility authorized to make disclosure. I understand that the revocation does not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition or on the following date: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that the information in my health record may include information relating to sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug use.

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State law. I understand that authorizing this disclosure is voluntary. I understand that I need not sign this authorization to assure treatment, payment, enrollment in health plan or eligibility for benefits. I understand that I may inspect and/or copy the information to be disclosed. I understand that if I have any questions about disclosure of my health information, I may contact the privacy officer that is authorized to disclose this information and request a copy of this authorization.

Signature of Patient or Legally Authorized Representative

_____/_____/_____
Date: MM/DD/YYYY

Name (first and last) of Person Signing this Release

If Signed by a Representative, Indicate the Relationship to Patient

This Authorization must be part of the patient's medical record. A copy of this authorization must be given to the Patient or legally authorized representative.