Authorization *for Release of Information*

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I hereby authorize the use of 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 healthcare provider, then the released information may be no longer be protected by federal regulations.

PATIENT INFORMATION

Patient ________________________ Date of Birth ________________ Phone # ____________________

Address/City/State/Zip ____

E-mail ______________________________ Cell Phone Number ____________________

Organization Releasing Information ____

Person/Organization Receiving Information __________________________________

Method of Transmission ❑ **Fax Number** ________________ ❑ **Email** ________________ ❑ **Pick up**

PURPOSE OF DISCLOSURE

❑ Continuation of Care ❑ Insurance ❑ Legal ❑ Personal ❑ Other: ______________________

DATES OF SERVICE TO BE RELEASED:

❑ ______ /______ /______ to ______ /______ /______

INFORMATION TO BE RELEASED *(Please check all that apply)*

❑ Entire Record
❑ Progress Notes
❑ Lab/Pathology Reports
❑ Ultra Sound Reports
❑ Operative Reports
❑ Last office visit & PAP
❑ Prenatal Flowsheet
❑ Other: ______________________
❑ 1 Year Medical Record Abstract (e.g. History and Physical, Operative, Report, Consults, Test Results, Discharge Summary)
❑ 2 Year Medical Record Abstract (e.g. History and Physical, Operative, Report, Consults, Test Results, Discharge Summary)

I understand that this authorization will expire 6 months from the date signed.

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it will not have any effect on actions they took before they received the revocation.

This medical record may contain information about drug abuse, alcohol abuse, abortion, sexually transmitted diseases, HIV testing and/or AIDS diagnosis treatment. Separate consent must be given before this information can be released.

Please initial beside one of the following indicating your consent.

I do consent to have this information released ____________

I do not consent to have this information released ____________

Signature of Patient or Guardian ______________________________ Date ______________

Printed name of Patient or Guardian ______________________________ Relationship ______________

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