AUTHORIZATION TO RELEASE AND/OR INSPECT HEALTHCARE INFORMATION

PATIENT NAME DOB

ADDRESS CITY STATE ZIP CODE

I hereby authorize:

NAME/FACILITY

STREET ADDRESS

CITY/STATE/ZIP CODE

To disclose my protected health information, as described below to:

NAME/FACILITY

STREET ADDRESS

CITY/STATE/ZIP CODE

INFORMATION TO BE RELEASED:

☐ OFFICE NOTES ☐ DISCHARGE SUMMARY ☐ PATHOLOGY ☐ IMAGING ☐ LAB

☐ HISTORY & PHYSICAL ☐ CONSULTATION ☐ OPERATIVE REPORT

REASON FOR DISCLOSURE:

☐ CHANGING PHYSICIANS ☐ PERSONAL ☐ LEGAL ☐ WORKERS COMPENSATION ☐ DISABILITY

☐ CONSULTATION/CONTINUING CARE ☐ PAYMENT OF INSURANCE CLAIM ☐ APPLICATION FOR INSURANCE ☐ OTHER

- A listing of the statutory exception to release HIV test results without consent is available.

I understand that the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information might be re-disclosed without my authorization.

I understand that I have the right to:

- Receive a copy of this authorization
- Refuse to sign this authorization and that treatment, payment, enrollment in a health plan or eligibility for health care benefits may not be contingent on my signing this authorization.
- Revoke this authorization, in writing, except to the extent that the person(s) and/or organization(s) listed above have already made in reference to this authorization.

This authorization will remain in effect for 6 (six) months or until otherwise specified and will be effective for medical records generated up to the date of this signature.

Signature of patient Print Name Date

(If signed by person other than patient, stated relationship to patient)

Patient is: ☐ Minor ☐ Incompetent ☐ Deceased Legal Authority: ☐ Parent or Legal Guardian ☐ Next of Kin of Deceased