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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize _____ to disclose information from the records of:

_____ (patient's name) _____ (date of birth).

This information is being released to:

_____ (doctor or facility).

For the purpose of:
___ continued care ___ insurance ___ personal ___ disability ___attorney

___ other (specify) _____

The information to be released is (itemize portions of the record and specify time period):

_____

_____

- I understand that I have the right to revoke this authorization at any time, I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Record Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. In understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and that the information may not be protected by federal confidentiality rules.
- If I fail to specify an expiration date, event or condition, this authorization will expire six months from the date of signature.
- I understand that the information in the 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 abuse.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to patient Witness

Method of Release:
- o mail to address above
- o call when ready; name _____; phone _____
- o will pick up; when? _____ picked up: _____