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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

THIS AUTHORIZATION REGARDING THE USE AND OR DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION IS REQUIRED UNDER FEDERAL LAW.

I, ________________________________ authorize __________________________ to use/release copies of
(Patient Name) (Physician or Organization)
medical and other information concerning my treatment, including but not limited to, information concerning drug abuse or drug-related conditions, alcoholism, psychological or psychiatric conditions, and including the release of information containing HIV testing, AIDS diagnosis, AIDS related conditions or sexual preference, or permit review of the same, provided, however, that such release is limited specifically to that described below:

Patient's **date of birth** and **SSN** for correct identification of records_______________/____________________
DOB SSN

Treatment Dates: ____

☐Office Notes ☐Lab Reports ☐Radiology (X-Ray) Reports
☐Operative/Pathology Reports ☐Other Test Results:____
☐Itemized Bill ☐Complete Medical Record

Specific Exclusions:____

The above information is to be released to:

Name of person or Organization:____

Complete mailing Address:____

The purpose of this disclosure is ☐Continuity of care/transfer/referral ☐Insurance ☐Legal ☐Personal

☐Other: ____

I understand that the information that is used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by the federal privacy rule (HIPAA).

I understand that this authorization may be revoked at any time except to the extent action has been taken prior to revocation. I may revoke this authorization in writing by contacting the physician's office personnel. However, I may not revoke in the event that action has been taken in reliance on such authorization or if the authorization was given as a condition of obtaining insurance. This consent will expire in sixty (60) days after the date below, or sooner at my election in which case this authorization will expire on _______________. I acknowledge that I have read and fully understand this authorization as it applies to me.

I understand that this authorization is voluntary and that I may refuse to sign it. Unless allowed by law, my refusal to sign this authorization will not affect my ability to obtain treatment.

________________________________ ________________________________
Date Signature of Patient

________________________________ ________________________________
Witness Other person legally authorized to give consent

____
Relationship to patient and reason

This information is being disclosed to the above-captioned individual/organization for the above stated purpose from records which are confidential and may be protected by Federal Law and/or State Law governing the release of drug and alcohol abuse; HIV testing and AIDS diagnosis; psychiatric/psychological conditions. This Authorization for Release of Information is in compliance with Federal & State Law & Regulations 42 USC 4582,42CFRPart2; OCR 3701.243