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AUTHORIZATION FOR RELEASE OF HEALTH INFORMAITON

Patient Name: _____**DOB:** _____

The person named above hereby authorizes _____(requesting provider) to:
□Request Health Information from □ Discuss Information with □ Send Information to

The person named above authorizes information to be requested or released by representatives of:

Name of Provider or Facility: _____
Address: _____
Fax: _____ Phone: _____

Specific Health Information Authorized:
□ I authorize disclosure of all my health information, including information relating to medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information; or

□ I authorize only the disclosure of the following information:
_____

Specific Health Information Requested (Requesting Provider to fill out): □ Entire Record / OR the following:

Last Visit Summary (Incl. Current Meds & Dx) □
Discharge Summary □
Emergency Room Visit Summary □
Individual Educational Plan (IEP) □
□ Other: _____

I understand and agree that:
• This authorization is voluntary;
• My health information may contain information created by other persons or entities including health care providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information;
• I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider, except to the extent that the information being requested may assist your health care provider in determining appropriate treatment.
• My health information may be subject to re-disclosure by the recipient, and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal privacy regulations;
• This authorization will expire one year from the date I sign the authorization. I may revoke this authorization at any time by notifying my provider in writing; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed.

Authorization:

Signature of Patient or Authorized Representative:_____

Date: _____Relationship if not Patient:_____