Authorization for Disclosure of Medical Information

Treatment, payment, enrollment or eligibility benefits will not be conditioned on my providing or refusing to provide this authorization. I hereby authorize

_____

(Name of Clinician/Doctor/Hospital sending records)

to release records/information as indicated below regarding:

Patient Name: _____ DOB: _____

Address: _____ Tel: _____

Release information **to**: _____

Name of Receiving Party

_____

Address

_____ _____

Telephone # Fax #

DURATION: This authorization shall become effective immediately and shall remain in effect until _____ (enter date) or for one year from the date of signature if no date entered.

REVOCATION: This authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. Written revocation will be effective upon receipt, but will not be effective to the extent that the requester or others have acted in reliance upon this authorization.

REDISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

SPECIFY RECORDS: Check the box to indicate the type of information to be disclosed:

□ Health Information Record □ Drug/Alcohol Record

□ Mental Health Record □ HIV Test Results

□ Other (Specify) _____

I request that the health information released pursuant to this authorization be used for the following purposes only:

_____

_____ _____

Signature of Patient or Patient's Representative Date

_____

Indicate Relationship (if signed by other than Patient)

I have received a copy of this authorization: _____ (Initial)

A copy of this authorization is valid as an original.