Authorization for Release of Information

Patient Name: Date of Birth:

Address:

Home Phone: Work Phone:

I hereby authorize: [Provider Full Title] to release information from my medical record as indicated below to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

INFORMATION TO BE RELEASED: DATES:

- ☐ History and physical exam _____
- ☐ Progress notes _____
- ☐ Lab reports _____
- ☐ X-Ray reports _____
- ☐ Other _____ _____

I specifically authorize the release of information relating to:

- ☐ Substance abuse (including alcohol/drug abuse)
- ☐ Mental health (including psychotherapy notes)*
- ☐ HIV related information (AIDS related testing)
- ☐ Marketing (except for face-to-face encounters or promotional gifts of nominal value)

X _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

**Please note that if this authorization is used for the purpose of psychotherapy notes that it may not be combined with any other authorization(s) unless for the purpose of psychotherapy notes.*

PURPOSE OF DISCLOSURE:

- ☐ Changing physicians
- ☐ Consultation/second opinion
- ☐ Continuing care
- ☐ Insurance
- ☐ Legal
- ☐ Research
- ☐ School
- ☐ Worker's Comp.
- ☐ Other (please specify):

1. I understand that this authorization will expire _____ days after I have signed this form.
2. I understand that if this authorization is used for the purpose of research, that it will expire at the end of research study or indefinite date if the authorization is used for the creation or maintenance of a research database or repository.
3. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
4. I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal and State privacy regulations.
5. I understand that if I am being requested to release this information by [Provider Full Title] for the purpose of: _____
   a. By authorizing this release of informatoin, my health care and payment for my health care will not be affected if I do no sign this form.
   b. I understand I may see and copy the information described on this form if I ask for it (permited by Federal law or State law to the extent the state law provides greater access rights), and that I will get a copy of this form after I sign it.
   c. I have been informed that [Provider Full Title] ☐ will/ ☐ will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
6. I understand that in compliance with [Practice S statue, I will pay a fee of $ _____. There is no charge for medical records if copies are sent to facillities for ongoing care or follow up treatment.
7. I understand that I may refuse to sign this authorization.

SIGNATURE OF PATIENT DATE

LEGAL GUARDIAN/AUTHORIZED PERSON DATE

RECORDS RECEIVED BY DATE

RELATIONSHIP TO PATIENT

FOR OFFICE USE ONLY

DATE REQUEST FILLED: _____ BY: _____

TYPE OF IDENTIFICATION PRESENTED AND EXPIRATION: _____ FEE COLLECTED: $_____