



AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

1) PATIENT INFORMATION:

NAME

Date of Birth

Daytime Phone

ADDRESS

CITY

STATE

ZIP

2) TO DISCLOSE TO:

- Self, Delivery Options: Pick up
- Mail to address above
- I hereby authorize _____ to pick up my records (photo ID required)
- Encrypted Email to _____

Send To: Name & Address of Health Care Provider / Plan / other

3) DATE(S) OF INFORMATION TO BE DISCLOSED:

From (month/year) To (month/year) Entire Record

If left blank, only information from the past two (2) years will be disclosed.

4) PURPOSE: (check all that apply - copy fees may apply*)

- Further Medical Care
- Insurance Eligibility / Benefits
- Other: _____
- Legal Investigation / Action
- Personal (at my request)

5) YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I am aware that have the right to inspect and receive a copy of the health information I have authorized to be used and / or disclosed by this Authorization. **I understand that I may be charged a fee for record copies.** In addition, I understand that i do not need to sign this authorization in order to receive treatment. I am also aware that I may revoke this authorization by notifying the disclosing medical records/ health information department in writing. However, I understand that my revocation will not be effective as to uses and / or disclosures: (1) already made in reliance upon this authorization; or (2) needed for an insurer to contest a claim/ policy as authorized by law if signing the authorization was a condition to obtaining insurance coverage. I realize that the information used and/or disclosed pursuant to

this authorization may be subject to re-disclosure and no longer protected by federal privacy law.

9) SIGNATURE OF PATIENT / LEGAL REP: _____ **DATE:** _____

If signed by a person other than the patient, complete the following:

1. Individual is: a minor
 legally incompetent or incapacitated
 deceased

 2. Legal Authority: parent
 legal guardian
 next of kin / executor of deceased
 activated POA for Health Care
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