AUTHORIZATION TO DISCLOSE HEALTH INFORMATION PERSUANT TO HIPAA

Patient Name: ____ Date of Birth: _________________________

By signing this form, I authorize (name and address of physician/clinic/entity)

____

to release confidential health information about me, by releasing a copy of my medical records, to the physician/clinic/entity listed below (name and address)

____

The health information that relates to dates of service from ______________________ to ______________________ may be released and may include (circle all that apply): Entire medical record, History & Physicals, Lab reports, Radiology reports, Treatment records, Pathology reports, Billing records, Insurance records, Medication records or Other: ____ (specify)

For the purpose of:

____

____

____ ____
Printed Name of Patient Signature of Patient or representative

____ ____
Date Printed name of representative and relationship

- I understand that unless revoked in writing, this authorization is valid for 12 months from the date of signing. I understand that I may revoke this authorization in writing at any time except to the extent disclosure has already been made in accordance with this document.

- Unless specifically excluded below, this authorization includes release of specially protected information including referral, diagnosis and treatment information related to my health care.

- (Please circle all that apply to **EXCLUDE** the information from authorization and disclosure):
  Substance Abuse Mental Health Conditions Sexually Transmitted Diseases HIV/AIDS

- I understand once my health care information is released, the person or organization that receives it may re-disclose the information and that it may no longer be protected by privacy laws.

- I understand release of my records may take up to 30 days.

- I understand that I do not have to sign an authorization as a condition for receiving treatment or health care benefits (treatment, payment or enrollment).

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