Authorization for Release of Health Information

Name of Patient _____ Date of Birth _____

Street Address _____ Social Security Number _____

City, State, Zip _____ Phone Number _____

I do hereby authorize _____ to release the information checked below:

___Discharge Summary	___Pathology Reports	___Consultations
___History and Physical	___Laboratory Reports	___EKG Reports
___Office Visit Notes	___Radiology Reports	___Progress Notes
___Billing Records	___Cardiology Records	___Other_____

I authorize the release of information related to:

	I do	I do not
• Aids/HIV	_____	_____
• Psychiatric Care/Assessment	_____	_____
• Treatment for alcohol/drug abuse	_____	_____

Information Released to: _____
Name of Company/Facility/Person

_____
Mailing Address

_____
City, State, Zip

Purpose of Disclosure:

Insurance ___	Disability ___	Personal ___
Workers Comp ___	Continue of Care ___	Legal Investigation ___

Other _____

Unless revoked earlier this consent will expire 180 days from date of signing, to revoke this request please contact the Medical Records Department.

I hereby authorize disclosure of the health information for the above names patient. This authorization is valid for 30 days from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclose by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition treatment of me on whether or not I sign the authorization. I understand and accept the statements contained in the authorization.

_____ _____
Signature of Individual (guardian or personal representative) Date