Authorization for Release of Health Information

Patient First & Last Name: _____

Patient DOB: _____ Medical Record #: _____

Patient Street Address _____

City/State/Postal Code: _____ _____ _____

I, or my authorized representative, request that health information regarding my care and treatment as set forth on this form:

In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize the release of such information to the person(s) indicated in Item 8.

2. If I am authorizing the release of HIV-related, alcohol, or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law.

3. I have the right to revoke this authorization at any time by writing to the healthcare provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).

7. Name of the Health Care Provider to Release the information:

_____

Provider Street Address _____

City/State/Postal Code: _____ _____ _____

8. Name of the person(s), organization, or another third party to whom this information will be released:

_____

Street Address _____

City/State/Postal Code: _____ _____ _____

9(a). Indicate the specific medical record information to be released

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiological studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Entire Medical Record for Specific Dates

☐ Other

If you chose "Entire Medical Record for Specific Dates," list the from and to dates for those records. For records from (date) _____ to (date) _____

If you chose "Other," indicate which records are to be released to the entity noted on 8. above.

_____

If you chose "Other," check any items to be included:

☐ Alcohol/drug treatment ☐ Mental health information

☐ HIV-related information ☐ Genetic testing

9(b). Authorization to Discuss Health Information. By initialing here, I authorize the entity listed below on line 9(c) to discuss my health information with my attorney, or a governmental agency, listed below on line 9(d). _____

9(c). Name of individual health care provider: _____

9(d). Name of attorney/firm or governmental agency: _____

10. Reason for release of the information

☐ Personal Use ☐ Other If you chose "Other," provide the reason below:

_____

11. Date or event on which this authorization will expire:

_____

12. If not the patient, name of the person signing the form:

_____

13. Authority to sign on behalf of the patient:

_____

All Items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____

Signature of Patient or representative authorized by law

_____

Printed Name

_____

Date signed