

**AUTHORIZATION TO RELEASE PERSONAL HEALTHCARE INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I authorize the disclosure and use of my health information as described below:

To be Released by:

To be Received by:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Phone/FAX \_\_\_\_\_

Phone/FAX \_\_\_\_\_

For the purpose of:  Adjunctive/Concurrent Care  Transfer of Care  Other: \_\_\_\_\_

I specifically authorize the release of the following information:

- Complete Chart Record *(does not include billing information or radiographic images)*
- Chart Notes:  All  Specify: \_\_\_\_\_
- Lab Results:  All  Specify: \_\_\_\_\_
- Imaging Reports:  All  Specify: \_\_\_\_\_
- Billing Records:  All  Specify: \_\_\_\_\_
- X-rays/Radiographic Images (specify): \_\_\_\_\_
- Other: \_\_\_\_\_

Unless specifically excluded, this authorization includes the release of specially protected information: referral, diagnosis and treatment information related to substance abuse, mental health/psychotherapy, and HIV/AIDS.

**Check the accompanying box(s) below to EXCLUDE the information from authorization:**

- substance abuse  mental health/psychotherapy  HIV/AIDS

**I understand the conditions of this authorization:**

1. Unless canceled by me, this authorization is valid for 12 months from the date of signing.
2. I may cancel this authorization in writing at any time except to the extent disclosure has already been made in accordance with this document.
3. If the person/organization receiving the health information is not a health plan or health care provider, the released information may no longer be protected by state and federal privacy regulations.
4. Not agreeing to or canceling this authorization may result in improper diagnosis or treatment, or denial of health benefits or other insurance coverage, but is not a condition for receiving medical treatment.
5. I am entitled to a copy of this authorization form at the time of signing.

\_\_\_\_\_  
**Patient's Name (PRINT)**

\_\_\_\_\_  
**Patient's Guardian/Representative (PRINT)**

\_\_\_\_\_  
 Signature of Patient

\_\_\_\_\_  
 Signature of Guardian/Representative

Date: \_\_\_\_\_

\_\_\_\_\_  
 Relationship to Patient/Representative

Date: \_\_\_\_\_