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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary, and that if the organization authorized to receive this information is not a health plan or healthcare provider, the release of such information may no longer be protected by federal privacy regulations. I also understand that once this information is disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient(s), and may no longer be protected by federal privacy regulations.

ALL ITEMS MUST BE COMPLETED

Patient Information:
Name: _____
Address: _____
_____
Phone Number: _____
Date of Birth: _____
Last 4 digits of SS#: _____

Person(s) or class of persons authorized to disclose the information:

Person(s) or class of persons authorized to receive the information:

Description of the information that may be disclosed: (please state clearly)

The information will be disclosed for the following purpose:

The patient (or the patient's personal representative, if applicable) must read and initial the following:

1. I understand that this authorization will expire on _____/_____/_____ or upon _____. Initials:_____
2. I understand that I may revoke this authorization at any time in writing except to the extent that action has been taken in reliance on this authorization. Initials:_____

_____
Signature of Patient or Patient's Personal Representative (as applicable)

_____
Date

_____
Name of Patient's Personal Representative (as applicable)

_____
Relationship to Patient or Statement of Authority to act On patient's behalf (e.g., spouse, Parent, legal guardian, etc.)

Please release this medical information to:

Name:

Address:

City/St/Zip:

Fax #: (if records to be faxed):