

Authorization for Release of Confidential Health Information

Individual Information:

_____/_____/_____
Date of Birth

Name

(_____)_____-_____
Phone #

Street Address

Suite / Apt.

City

State

Zip

Information may be disclosed by:

Name of organization or person releasing information

Street Address

Suite / Apt.

City

State

Zip

(_____)_____-_____
Phone #

(_____)_____-_____
Fax #

Information may be disclosed to:

Name of organization or person to receive information

Street Address

Suite / Apt.

City

State

Zip

(_____)_____-_____
Phone #

(_____)_____-_____
Fax #

Information to be disclosed:

Choose only ONE option. Copy fees may apply.

- Information from the most recent 2 years of office visits
- All information from date: ____/____/____ to date: ____/____/____
- Information regarding specific treatment, condition, or other (specify): _____

Why are you asking for this health information to be released?

Choose only ONE option. Copy fees may apply.

- Attorney
- Insurance
- Doctor
- Medical Leave
- Personal
- Other: _____

Authorization:

This authorization expires 60 days from the date signed or on the date or event indicated here:

Information released may include any of the following: laboratory reports, x-ray reports, operative notes, and information regarding the testing, diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, chemical dependency, or mental/psychiatric illness. By my signature, I give my specific authorization to be released.

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Printed Name

Signature

Date Signed

Relationship to Patient: Self

Parent

Legal Guardian

Power of Attorney