AUTHORIZATION TO DISCLOSE HEALTH INFORMATION: PLEASE PRINT

Name LAST ________________________FIRST___________________ MIDDLE___________________
ADDRESS:____________________________________CITY______________ STATE _______________

ZIP_______________ PHONE: ________________BIRTHDATE: ___________________________

SOCIAL SECURITY #_____________________________

I AUTHORIZE THE FOLLOWING INDIVIDUAL OR ORGANIZATION TO MAKE THE DISCLOSURE:

PROVIDER (Releasing records) /FACILITY NAME:_________________________________

ADDRESS:______________________________________CITY_________________- STATE____________
ZIP ________PHONE: (   )_______________ FAX: (   )___________

INFORMATION MAYBE DISCLOSED TO THE FOLLOWING INDIVIDUAL OR ORGANIZATION

PROVIDER/FACILITY (Recieving Records):____

ADDRESS:____

PHONE: (   )______________________ FAX: (   )________________________________

INFORMATION TO BE DISCLOSED:

All Records from (DATES)___________to __________

Progress notes ___________________

Operative Notes: _______

Laboratory results:___________

Radiology Reports (ultrasound, mammo, CT, Xray):___________

FOR THE PURPOSE OF: Continuing medical care_____________ Other________________

I understand that information in my health record may include information relating to sexually transmitted disease, immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

REVOCATION: I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply: (1) to information that has already been released in response to this authorization or (2) to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

AUTHORIZATION : I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I hereby authorize the above individual/organization to disclose health information concerning the above named patient to the party identified in the section titled “Information may be disclosed to”

SIGNATURE OF PATIENT OR REPRESENTATIVE________________________ DATE_______________