

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Name _____
Last First MI

Date of Birth _____ Social Security # _____

Address _____
Street City State Zip

Primary Phone # _____

I do hereby authorize _____ to release:
(Name of Facility)

My health information relating to the following treatment or condition: _____

My health information for the date(s): _____

Other: _____

I do I do not authorize the release of information related to AIDS, HIV, psychiatric care and/or psychological assessment and treatment for alcohol and/or drug abuse.

Release information to: _____
Name of Company/ Agency/ Facility/ Person

Street Address

City State Zip Code

Purpose of Disclosure:

- | | | |
|---|---|-----------------------------------|
| <input type="checkbox"/> Referral to Specialist | <input type="checkbox"/> Insurance | <input type="checkbox"/> Personal |
| <input type="checkbox"/> Continuing Care | <input type="checkbox"/> Change of Doctor | <input type="checkbox"/> Other |

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations.

Signature of Individual or Guardian

Date