

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

To be completed by the patient to authorize disclosure to self or others

Patient Name social security/account number

Date of Birth Address and Phone Number

1. I authorize the use or disclosure of the above individual's health information as described below:
2. The following individual or organization is authorized to make the disclosure:

Address/phone/fax number

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)
 - Entire Record
 - Most recent history and physical
 - Most recent discharge summary
 - Operative report(s)
 - Laboratory results from (date) _____ to (date) _____
 - Sonogram/x-ray/imaging reports from (date) _____ to (date) _____
 - Consultation report(s)
 - Other _____
4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired 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.
5. This information may be disclosed to and used by the following individual or organization.

Address/phone/fax number

For the purpose of:

6. 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 address below. 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 provided my insurer with the right to contest a claim under my policy.
7. 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, the authorization will expire in 6 months)
8. I understand and agree to pay for the cost of copying the requested records.
9. 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.
10. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524
11. I understand any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.
12. If I have questions about disclosure of my health information, I can contact the clinic's privacy officer (Cathy Torres)

Signature of Patient or Legal Rep Date

If signed by legal rep, relationship to patient WITNESS