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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Name of Patient

Birth Date

Street Address

City, State, Zip Code

I hereby authorize:

To disclose my protected health information, as described below, to:

Name of individual or entity

Name of individual or entity

Street Address

Street Address

City, State, Zip code

City, State, Zip code

Information to be released:

Medical history, Examination reports

Surgical reports

Prescriptions

Hospital records including reports

Consultations

Drug abuse

Laboratory reports

Allergy records

All records

Sexually transmitted Disease

HIV test results

X-ray reports

Other (please specify) _____

*A listing of the statutory exceptions to release of HIV test results without consent is available.

Purpose for need of disclosure:

At the request of the individual

I understand that the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information might be redisclosed without obtaining my authorization.

I understand that I have the right to:

- **Receive copy of this authorization.**
- **Refuse to sign this authorization** and that treatment, payment, enrollment in a health plan or eligibility for health care benefits may not be contingent on my signing this authorization.
- **Revoke this authorization**, except to the extent that the person(s) and or organization(s) listed above have already made in reference to this authorization.

I understand that there is a \$25.00 copy fee.

This authorization will remain in effect until the following date(s): _____

Signature of patient (or legal representative)

Date

If signed by Legal Representative:

Relationship of patient (authority to act on patient's behalf)

Date