AUTHORIZATION for RELEASE of HEALTH INFORMATION

Patient Name:_____ Date of Birth: ___/___/_____

Address: _____ City: _____State:_____ Zip code:_____

I authorize Dr. _____ to release my health information starting

with the Date from: _____ to present.

Send Records to:

Dr._____

Address:_____ City:_____State:_____ Zip code:_____

Telephone Number: _____ Fax Number: _____

I request the information below to be released: (check all that apply)

__ Medical History / Examination reports ___ X-Ray __Complete Medical Record ___ Prescriptions
__Hospitalization ___ EKG ___ Other_____

Purpose for the disclosure:
___ At the request of the patient
___ Transferring from practice

I understand that if the authorized recipient is not a provider, health plan, or clearinghouse required to comply with federal standards, the information disclosed pursuant to this authorization may no longer be protected by federal privacy standards. I understand that the information in my health record may include information relating to HIV/AIDS, behavioral/mental health, and drug/alcohol abuse. I understand that I may refuse to grant consent to release this type of information.
I understand that I have the right to

- Revoke this authorization except if the organization listed has acted upon this request prior to my request of revocation
- Refuse to sign this revocation
- Receive a copy of this revocation

Patient Signature: _____ Date: ___/___/_____

Legal Representative: _____Relationship to Patient:_____