

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

**Patient/Resident Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_  
**City/ State/ Zip:** \_\_\_\_\_ **Maiden/Previous Names:** \_\_\_\_\_

**Release Information From: (Who has your records)**

Name/Facility: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Phone: \_\_\_\_\_

**Release Information To: (Who needs your records)**

Name/Facility: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Phone: \_\_\_\_\_

**All records pertaining to Psychiatric/Mental Health, Alcohol, and/or Drug Dependency, and/or HIV/HPV related illness will not be released unless specifically authorized below in writing. (I specifically authorize the release of the following)**

Psychiatric/Psychological \_\_\_\_\_ Initials     HIV \_\_\_\_\_ Initials     Drug and/or Alcohol Dependency \_\_\_\_\_ Initials  
 Ongoing written/verbal for the above information

**Check if applicable – Notice to Whomever Disclosure is made concerning addiction records.**  
This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2, a general authorization for the disclosure of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patients.

**Information to be Released:** Service Dates: FROM: \_\_\_\_\_ TO: \_\_\_\_\_

**Circle:**  Provider Note     X-ray Reports     X-ray Films- X-Ray CDs/Flash drive (fees may apply)  
 Laboratory Reports     Emergency Room Record     Discharge Summary     Billing Information  
 Current Medication List     Advance Directives     PT/OT/SLP Therapy     Operative Report  
 Complete record (Hospital or Clinic).     Other \_\_\_\_\_ (One year history unless otherwise specified)  
For the following date(s) of treatment or condition: \_\_\_\_\_

**Delivery Time Frame:** Date information desired by: \_\_\_\_\_

**Purpose:**  Continued care     Personal use     Legal     Military     Insurance/ Billing     Wellness  
 Worker's Comp     Other \_\_\_\_\_

**This authorization shall remain in effect until the following date, event or condition:** \_\_\_\_\_  
If no date, event or condition is specified, this authorization will expire in one year.

**Release Format:** Circle: Oral    Written    USB    My Chart    FAX Number: \_\_\_\_\_

This information remains in effect until the above date, event, or condition, unless specifically revoked by written notice to the individual or organization. I understand that this authorization may be revoked at any time. Any information released prior to my written revocation of this authorization shall not be breach of confidentiality. I understand this may include information regarding mental health, alcohol/drug use, and HIV treatment. I understand that once disclosed, information may be re-disclosed by the recipient and no longer protected. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and will not affect my ability to obtain treatment, receive payment, or my eligibility for benefits. I understand that I may inspect, or request copies of any information disclosed under this authorization and that I am entitled to a copy of this authorization form once I have signed it. I understand that if the individual or organization that receives the information is not a health care provider or health plan covered by federal privacy regulations the information described above may be redisclosed and no longer protected by federal regulations.  
To be valid this form must be filled out completely and signed. A photocopy of this authorization is valid if it has not been altered.

Signature: \_\_\_\_\_ Validation Date \_\_\_\_\_

Reason patient is unable to sign: (Circle) Minor    Deceased    Guardian

Print Name of Person Signing (if not patient state Legal Representative or Relationship to patient/resident)

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Circle: To be mailed    Picked up    Called when ready    By what date \_\_\_\_\_

Completed by: \_\_\_\_\_ Date: \_\_\_\_\_