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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency laboratory test results, medical history, treatment, or any other such related information. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive this information is not a covered entity, e.g. insurance company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations.

Patient Name: ______________________________ **SSN:** ________________

Phone Number: ______________________________ **DOB:** ________________

Dates of Service (if known): ____

Description of information to be released: (Check all that apply)

☐ Consultation Report ☐ Operative Reports ☐ Nurse's Notes ☐ Other: ______________

☐ Progress Notes ☐ Entire Chart ☐ Billing Records ☐ Discharge Summary

☐ Radiology Reports ☐ Psychotherapy Notes *(by checking this box, I am waiving any psychotherapist-patient privilege)*

Description of the purpose of the use and/or disclosure:

☐ Further Medical Care ☐ Personal Use ☐ Attorney ☐ Insurance ☐ Disability

☐ Research ☐ School ☐ Other *(Specify)*: ______________________________

Medical Provider to release records:

Name ______________________________
Address ______________________________
____
Phone ______________ Fax ______________

Persons/Organizations Receiving the information

Name ______________________________
Address ______________________________
____
Phone ______________ Fax ______________

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until ________________. I further understand that I may revoke this authorization at any time by notifying the providing organization in writing and if I do it will not have any effect on any actions they took before they received the revocation. I understand that I may see and copy the information described on this form if I ask for it, and that may receive a copy of this form after I sign it if I ask for it. Further, I understand there may be a fee for a copy of this information.

______________________________ Date ______________
Signature of Patient or Representative *(State relationship to patient)*

______________________________ Date ______________
Signature of Witness *(Clinic Representative or notary)*

*This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a federal agency under false pretenses shall be guilty of a misdemeanor Privacy Act of 1974(5 USC 552a (i) (3)).