Authorization to Disclose Health Information

Patient Name: _____ Social Security Number: _____
Date of Birth: _____

1. I authorize the use or disclosure of the above-named individual's health information as described below.

2. The following individual or organization is authorized to make the disclosure:
FACILITY or PROVIDER NAME:_____
ADDRESS: _____
The type and amount of information to be used or disclosed is as follows:
____ most recent history and physical
____ medication list
_ __ list of allergies ____ laboratory results
____ all chart notes
____ all dental records
from (date) _____ to (date) present_____
____ x-ray and imaging reports
from (date) _____ to (date) present_____
____ consultation reports
from (doctor's names) _____ _____
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). I may 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:**
_____
_____
_____.

6. I understand I have a right to revoke this authorization at any time. I understand that if I revoke the authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, which by law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, the authorization will expire on the following date, event, or condition:
_____. If I fail to specify an expiration date or condition, this authorization will expire in six months.

7. 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 ensure treatment. I understand that I may inspect or copy information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for unauthorized redisclosure and the information may not be protected by confidentiality rules.

_____
Signature of Patient or Legal Representative Date

_____
If Signed by Legal Representative, Relationship to Patient

_____
Signature of Witness Date