Release of Confidential Information

I _____, hereby authorize _____to
(Name of patient or authorized agent) *(Name of physician)*

release to_____
(*Health care facility, physician, agency, etc)*

_____
(Street address, city, state, zip code)
the following information contained in the patient record of _____
(Patient name)

born_____, residing at _____
(Birth date) *(Street address, city, state, zip code)*

☐ The entire medical record, excluding mental health treatment, alcoholism treatment, and HIV acquired immune deficiency syndrome (AIDS) records.

☐ Mental Health Treatment Records

☐ Alcoholism Treatment Records

☐ Drug Abuse Treatment Records

☐ HIV/Acquired Immune Deficiency Syndrome (AIDS) Records

☐ Other_____

☐ Laboratory Reports

☐ X-ray Reports

☐ Operative Notes

The above information can be released during the following period of time: From: _____to_____

The purpose(s) of the authorization (are)_____

☐ I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above described information, I understand that it will not be disclosed, except as provided by law.

☐ I understand that the practice may not condition treatment on whether I sign this authorization except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.

☐ I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.

☐ I understand that this authorization is valid until it expires, unless revoked before that.

☐ I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the physician's office. Absent such written revocation, this Authorization for Release of Confidential Health Information will terminate on _____.

Signed:_____ Date:_____