Authorization for Release of Health Information

Patient Name:

Date of Birth:

Provider/Facility Releasing Information:

To release my health information to:

Information to be Released

- ☐ All health records
- ☐ Treatment notes
- ☐ Billing/Insurance records
- ☐ Other (specify):

Purpose of Disclosure

- ☐ Continuity of care
- ☐ Personal use
- ☐ Insurance/Payment
- ☐ Other (specify):

Expiration of Authorization

This authorization will expire on:

(If left blank, one year from the date of signing)

Patient Rights

- I may revoke this authorization in writing at any time.
- Revocation does not apply to records already released.
- My treatment, payment, enrollment, or eligibility for benefits will not be conditioned on signing this form.
- Information disclosed under this authorization may be re-disclosed by the recipient and may no longer be protected by HIPA

Signature

Patient/Legal Representative Signature:

_____ (Sign here if printing)

Date:

Printed Name of Legal Representative (if applicable):

Relationship to Patient: