



AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient: _____ Date of Birth: _____

SSN: _____ Previous Name: _____

I request and authorize _____ to release healthcare information of the patient named above to:

This request and authorization applies to:

_____ Healthcare information relating to the following treatment only: _____

_____ All healthcare information

_____ Other: _____

Information is needed for:

_____ Continuing Medical Care _____ Personal Use _____ Social Security/Disability

_____ Insurance _____ Legal Purposes _____ Other: _____

The above information may be released to (specify name or title of individual or the same name of the organization to which records are to be released and the appropriate address):

Doctor, Hospital, Attorney, Insurance Company, Self, etc. Phone Number

Address (Street, Suite #, City, State & Zip Code)

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but not limited to history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand that treatment or payment cannot be conditioned on my signing this authorization. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

This authorization will expire in One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time or unless otherwise specified by date, event or condition as follows:

Signature of patient

Date signed

Patient's authorized representative

Relationship