

AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF MEDICAL INFORMATION

Patient Name

Date of Birth

Please **REQUEST** Medical Information **FROM**:

Please **SEND** Medical Information **TO**:

Person/Organization Name

Person/Organization Name

Address

Address

City, State, Zip Code

City, State, Zip Code

Phone Number

Fax Number

Phone Number

Fax Number

I hereby authorize _____ to release and/or disclose the medical information as indicated below to the health care provider, entity, or person I have indicated above.

Treatment, payment, enrollment, or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.

The health information will be released and/or disclosed for the following purpose(s):

<input type="checkbox"/> Treatment/Continuing Medical Care (e.g. Other Healthcare Providers, Hospital, Physicians)	<input type="checkbox"/> Legal purposes (e.g. Attorneys)	<input type="checkbox"/> Personal Use
<input type="checkbox"/> Billing or Claims	<input type="checkbox"/> Insurance (e.g. life insurance application)	<input type="checkbox"/> Disability Determination
<input type="checkbox"/> School	<input type="checkbox"/> Employment	
<input type="checkbox"/> Other, please specify: _____		

Check the box which type of information is to be released and/or disclosed:

- General Medical Information (from _____ to _____)
- Information regarding Specific Treatment (from _____ to _____)
- Lab Results (from _____ to _____)
- Other, please specify: _____
- Entire medical record (including genetic testing, alcohol and/or drug use or sexually transmitted diseases).

This authorization expires on/upon _____
(insert date or event that triggers expiration)

I understand that my health information may be re-disclosed by the persons or organizations receiving my medical information, and that it may no longer be protected by federal or state privacy laws.

I understand that I may revoke this authorization at any time by notifying the disclosing party in writing. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

Signature of Patient

Date

If this authorization is signed by a patient's personal representative on behalf of the patient, please complete the following:

Name of Personal Representative

Relationship to Patient