**AUTHORIZATION TO RELEASE HEALTH INFORMATION**

This form authorizes to use and disclose the health information of the patient for the purpose described below.

**(Name of Practice)**

**Patient Name:**

**(Last) (First) (Middle Initial)**

**Date of Birth: Primary Contact Number: ( )**

🞏 Home 🞏 Cell 🞏 Work

**Mailing Address:**

**(City) (State) (Zip)**

**(Street)**

**RECEIPIENT(S):** This practice may disclose the information checked below to the following persons or entities, or classes/categories of persons or entities for the purpose indicated on this form.

Name:

Contact Person/Department: Phone: ( )

Mailing Address:

**(City) (State) (Zip)**

**(Street)**

**CHECK THE TYPE(S) OF INFORMATION TO BE USED AND/OR DISCLOSED:**

🞏 Entire record 🞏 Financial/insurance records 🞏 Office visit notes 🞏 Psychotherapy Notes\*

**\***If psychotherapy notes are requested no other boxes can be checked/other records can be requested with this form.

🞏 Lab/diagnostic results related to: 🞏 Records from: to

mm/dd/yyyy

mm/dd/yyyy

🞏 Records specific to a certain condition/treatment:

🞏 Other (describe):

Photos & Multimedia: 🞏 Photo received from patient or personal representative 🞏 Photo taken by staff (e.g., pre/post procedure) 🞏 Other clinical images (e.g., X-ray) 🞏 Other:

Photos/Images may be posted: 🞏 In Office 🞏 On website 🞏 Other:

**Do not include**:

🞏 Mental health records 🞏 Communicable diseases (including HIV/AIDS) 🞏 Alcohol/drug abuse treatment

**FORMAT/DELIVERY (IF APPLICABLE)**

🞏 Paper/mail 🞏 USB/CD-ROM 🞏 Encrypted Email:

🞏 Secure Portal (name): 🞏 Other:

**Transmission must meet HIPAA security standards. Security risk cannot be waived by patient.**

(continued on back)

**PURPOSE FOR THE USE OR RELEASE:**

🞏 This practice will receive direct or indirect payment because of this authorization (marketing or fundraising).

🞏 This practice will receive direct or indirect payment that is more than the usual cost-based fee to prepare and transmit the information for this purpose – or other fee specifically permitted by law (typical for a sale of PHI).

**EXPIRATION DATE OR EVENT**

🞏 One-time use/disclosure of information 🞏 This information may be used/disclosed until:

mm/dd/yyyy

🞏 Release this information until the end of a treatment or other event (e.g., research study):

**PATIENT RIGHTS**

* You have the right to revoke/stop this authorization at any time in writing. Exceptions to this are listed in our Notice of Privacy Practices. A revocation/termination does not apply to releases of information that took place before the written revocation/termination was received by this practice.
* Information used or disclosed as permitted by this authorization may be redisclosed by the recipient and no longer protected by federal or state law.
* You have the right to refuse to sign this authorization. You are not required to sign this authorization in order to receive treatment from this practice.
* You understand PHI to be released may include a communicable disease diagnosis such as HIV or a diagnosis related to mental health or substance abuse unless it is excluded above.

mm/dd/yyyy

Patient or Personal Representative Signature Date

Printed name and description of Personal Representative’s Authority (attach necessary documentation if not already provided)

**FOR OFFICE USE & REFERENCE ONLY**

* This authorization has been revoked:

mm/dd/yyyy

The revocation/cancellation must be in writing and filed with the original authorization.

Date original signed authorization received:

mm/dd/yyyy

Use/Disclosure/Release date:

mm/dd/yyyy

Fee charged: 🞏 Copy provided to patient/personal representative

Notes: