Authorization to Release Health Information

**Patient Information:**

Name of Patient: Date of Birth:

Address:

City, State, Zip: Phone:

##  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ may release the following information on behalf of the patient:

 (Name of the entity)

|  |  |  |
| --- | --- | --- |
| * Entire record
 | * Financial records
 | * Office visit notes
 |
| * Marketing\*
 |  |
| * Psychotherapy notes – if this box is checked only psychotherapy notes may be released.
 |
| * Diagnostic studies (list):
 |
| * Other (list):
 |

\*Financial compensation is received for this communication.

**Entity or person who will receive the information:**

Name:

Address:

City, State, Zip: Phone:

* **Send the information electronically. Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Acknowledge for email and/or text communication** I understand that if information is *not* sent in an encrypted (secure) manner, there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.

**This authorization shall be in effect until** **the information has been forwarded as requested, until the course of treatment is complete, or until revoked by the patient in writing.**

##### Patient’s Rights:

* I have the right to revoke this authorization at any time in person or in writing.
* I may inspect or copy the protected health information to be disclosed as described in this document.
* Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
* Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
* I may refuse to sign this authorization and that my treatment will not be conditioned on signing*.*
* I understand released information may include a communicable disease diagnosis such as HIV or a diagnosis related to mental health or substance abuse.

## This authorization will remain in effect until revoked by the patient in writing.

Signature of Patient or Personal Representative: Date:

\*Description of Personal Representative’s Authority (attach necessary documentation)

|  |
| --- |
| REVOKEDHow: 🞎 in person on . (date) If in person, signature is required.Signature of Patient or Personal Representative: 🞎 in writing (place copy in patient’s file)  |