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Authorization for the Release of Medical Information

Patient Name:_____Date of Birth:_____
Street Address:_____
City, State, Zip:_____
Patient identifier (SSN):_____Phone:_____

I hereby authorize:_____(health care provider) to disclose or transfer my protected health information as indicated below.

The information is to be disclosed to:

Name -or- Practice:_____
Attention of:_____
Street Address:_____
City, State, Zip:_____
Phone:_____Fax:_____

Description of information to be disclosed:

For the dates of treatment between _____ and _____ dates.
Reason for requested use or disclosure:
[ ] Transfer of health coverage [ ] Personal use [ ] Form Completion
[ ] Referral [ ] Change in health care provider [ ] other
This authorization expires one year from the date of signature or earlier:_____

TO BE READ AND SIGNED BY PATIENT:

I understand the following:
a. I may revoke this authorization at any time by providing Written notice to the practice.
b. I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance coverage
c. The disclosing provider Will not condition treatment or payment based on my signing this authorization.
d. I am signing this authorization freely and under no pressure from any individual to do so.
e. The information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA or other privacy laws.
f. I acknowledge that l have had an opportunity to review this authorization and understand its intent and use.
g. I will receive a Copy of this completed and signed authorization form.
There Will be a charge of 75 cents per page for copying medical records plus cost of mailing.

Patient Signature:_____Date:_____