Authorization for Release of Protected Health Information

Patient Information
Full Name:
Date of Birth:
Mailing Address:

Transmission format:
☐ Mail
☐ Fax
☐ Encrypted email

Recipient:
Name:
Mailing Address:

Phone number:
Fax number:
Email address:

I hereby voluntarily authorize _____ to disclose the medical information indicated below to the above-listed Recipient. The information to be disclosed is:

☐ Entire Medical Record
☐ Medication List
☐ Lab Results
☐ Care Plans
☐ Only medical information from the period of _____ to _____
☐ Other (specify): _____

If you would like any of the following sensitive information disclosed, please indicate with a check mark below:

☐ Alcohol/Drug Abuse Treatment
☐ HIV/AIDS-related Treatment
☐ Mental Health (other than psychotherapy notes*)

The purpose of this disclosure is for _____ OR at the request of the individual.

This authorization shall become effective immediately and shall remain in effect until _____ (date) OR the occurrence of the following event _____, OR for one (1) year from the date of signature if neither a date nor event is entered, unless revoked earlier.

As of the signing of this authorization, I understand that I am giving permission to the above-named health care entity for disclosure of confidential health records. I understand that the health care entity may not condition treatment, payment, enrollment, or eligibility for benefits on my willingness to sign this authorization unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this authorization. I also understand that I have the right to revoke this authorization at any time, but that my revocation is not effective until delivered in writing to the person who is in possession of my health records and is not effective as to health records already disclosed under this authorization. A copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original health records. I understand that I am entitled to, and will be provided with, a signed copy of this authorization. I also understand that health information disclosed under this authorization might be redisclosed by a recipient and may, as a result of such disclosure, no longer protected to the same extent as such health information was protected by law while solely in the possession of the health care entity.

Patient Signature: _____ Date: _____

Authorized Representative Name and Relationship to Patient (if applicable): _____

Description of Authority to Act for the Patient (attach documentation): _____

Authorized Representative Signature (if applicable): _____ Date: _____

**Psychotherapy notes* means notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. 45 C.F.R. 164.501.