

## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient name: \_\_\_\_\_ Date/time request received: \_\_\_\_\_

Patient address: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Patient phone number: \_\_\_\_\_

I authorize: \_\_\_\_\_

To release my medical records to: \_\_\_\_\_

Address and/or fax#/phone of the recipient or where my health information should be delivered: \_\_\_\_\_

Specific information to be released: \_\_\_\_\_

Dates of service from: \_\_\_\_\_ to \_\_\_\_\_

Specific purpose of release: \_\_\_\_\_

*Note: At the request of the patient, it is sufficient if the patient is initiating this authorization.*

HIV, behavioral health, and drug and alcohol treatment contained in the parts of the record(s) indicated above will be released through this authorization unless I request otherwise by checking here:

Exception: I do not give permission to release (please specify): \_\_\_\_\_

I understand that the provider may not hinder treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

I acknowledge that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient.

I understand that this consent may be revoked by me at any time by submitting a written revocation notice, except to the extent that action has been taken in reliance thereon, and that this consent will remain in force in order to effectuate the proposes for which it is given unless revoked by me.

I understand that my authorization will remain effective for a period of 90 days from date of my request.

Patient's signature: \_\_\_\_\_

Date: \_\_\_\_\_ Signature of witness: \_\_\_\_\_

If individual is unable to sign this authorization, please complete the information below:

Name of guardian/representative: \_\_\_\_\_ Legal relationship: \_\_\_\_\_

Date: \_\_\_\_\_ Witness: \_\_\_\_\_