AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name _____

Patient Address _____

_____

Patient Phone number _____ Patient Number_____

Medical Records from : _____

_____

_____

I authorize the professional office named above to release health information identifying me (including if applicable; information about HIV infection or AIDS, information about substance abuse treatment and information about mental health services) under the following terms and conditions:

1. Description of information to be released; ____ all records
   _____ records from : _____ to _____
   _____ other :

2. To whom the information is to be released:

   _____

   _____

   _____

3. Purpose for the release: ____ at the request of the individual
   ____ other: _____

4. Expiration date or event relating to the individual or purpose for the release: _____

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.
If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written note telling us that your authorization is revoked.
When your health information is disclosed as provided in this authorization, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated _____ Patient Signature _____

If you are signing as a personal representative of the patient . describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____ Print Name _____

Source of Authority _____