AUTHORIZATION FOR RELEASE OF INFORMATION **TO :**

I hereby authorize :

Entity or Person from whom records are requested | Address

Telephone | Fax | City | State | Zip

to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not have to sign this form. I understand that if the recipient authorized to receive the information is not a covered entity , e.g. insurance company or non- health care provider; the released information may no longer be protected by federal and state privacy regulations.

Patient Name (please print) | Date of Birth

Patient Address (city state and zip) | Social Security Number

Specific Date(s) of Service ☐ All Dates of Service | Phone Number

Information to be release: (please check all that apply)

☐ **Complete Medical Records** ☐ Radiology Reports and Films ☐ Registration Records ☐ Billing Records

☐ Visits & encounters ☐ Laboratory Reports ☐ Consultation Reports ☐ Emergency Room

☐ laboratory Reports ☐ Operative Records ☐ Others

Description of the purpose of the use and/or disclosure:

The health information described herein shall be **released to** : (please circle the one that applies)

Category: Hospital Physician Insurance Company Attorney Patient Other

Name of Person or Entity (please print) | Phone Number

Address (City, State and Zip) | Fax Number

Delivery Method: ☐ Mailing Address ☐ Fax ☐ Pick-Up Records

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until_____(Expiration date/event.)

I further understand that I may revoke this authorization at any time by notifying this practice in writing. I also understand that the written revocation must be signed and dated with a date that is later then the date of this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

SIGNATURE OF PATIENT, PARENT, OR LEGAL GUARDIAN | DATE