**AUTHORIZATION FOR DISCLOSURE OF
HEALTHCARE INFORMATION**

Company Name: ____

Address: City_______________________ State: ___ Zip: _________

Phone: ___________________ Fax:________________

Patient Name: ____

Date of Birth: ____

SSN #: ____

Phone: (H) __________________________ Cell_____________________________

(W) _______________________________ Fax______________________________

Email:______________________________

I hereby authorize staff of the Medical Records Department of ____________________

____ to disclose protected health information about me to:

(Full Name and Title: Hospital, Agency, Health Care Provider, etc). ____________________

____

Street Address Mailing Address

____

City __________________________________State________________ Zip___________

Phone________________________________ Fax_________________________________

(Provide the full name or other specific identification of any other persons) or class of person(s) to whom disclosure may be made)**:** ____________________________________

____

THE INFORMATION TO BE RELEASED IS TO BE USED FOR THE PURPOSE OF: ❑ Attorney ❑ Referring Physician ❑ Insurance Company ❑ Workers' Compensation ❑ Disability (SS) ❑ At Request of the Individual ❑ Other

____

____

I REQUEST RELEASE OF THE FOLLOWING SPECIFIC INFORMATION FOR SPECIFIC DATE OF SERVICE:

❑ History /Initial and Interim Evaluations ❑ Treatment Progress Notes
❑ Prescription Orders
❑ Medications ❑ Entire Visit
❑ Other:
____

Specific Treatment Dates:

• You have the right to revoke this authorization by doing so in writing and submitting your request to the Medical Records Department of____

Your revocation will not apply to information that has already been disclosed in reliance on this authorization.

• Authorizing the use or disclosure of information identified above is voluntary and I need not sign this form to obtain healthcare treatment.

• Once the information is disclosed, it may be subject to re-disclosure by the recipient and federal privacy laws or regulations may no longer protect the information.

• I release the above named facility from liability and claims of any nature pertaining to the disclosure of requested protected health information pursuant to this authorization.

• This authorization expires upon the occurrence of or on the following date_________________________
(but not more than 12 months from the date of this authorization).

Signature: _______________________________________**Date**: ________________________

(Circle One) Patient Parent Spouse Guardian Personal Representative

If patient is unable to consent give reason (minor, incompetent, etc). When the individual initiates the authorization and does not, or elects not to, provide a statement of purpose.