

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Name of Patient

Birth Date

Street Address

City, State, Zip Code

I hereby authorize:

To disclose my protected health information, as described below, to:

Name

Name of Individual or Entity

Street Address

Street Address

City, State, Zip Code

City, State, Zip Code

Information to be released:

- Medical History, Examination Reports
- Treatment or Tests
- X- Ray Reports
- Laboratory Reports
- HIV Test Results*
- Mental Health
- Sexually Transmitted Disease
- Alcoholism

- Surgical Reports
- Hospital Records including Reports
- Developmental Disabilities
- Prescriptions
- Consultations
- Allergy Records
- Drug Abuse
- Other (Please specify) _____

* A listing of statutory exceptions to release of HIV test results without consent is available.

Purpose for Need of Disclosure

At the request of the individual

I understand that the health information disclosed as a result of this authorization may no longer be protected by the Federal privacy standards at my health information might be redisclosed without obtaining my authorization.

I understand that I have the right to:

- **Receive Copy of This Authorization**
- **Refuse to Sign This Authorization** and treatment, payment, enrollment in a health plan or eligibility for health care benefits may not be contingent on my signing this authorization.
- **Revoke This Authorization**, except to the extent that the person(s) and or organization(s) listed above have already made in reference to this authorization

This authorization will remain in effect until the following date(s): _____

Signature of Patient (or Legal Representative)

Date

If signed by Legal Representative:

Relationship to Patient (authority to act on patient's behalf)

Date