RELEASE OF INFORMATION AUTHORIZATION FORM

Patient/Client Name: _____

Date of Birth: _____ Phone Number: _____

1. Authorization to Release Information:

I hereby authorize the disclosure of my individually identifiable health information as described below to the designated recipient(s). I understand that this authorization is voluntary and I may revoke it at any time by providing a written notice to the releasing entity, except to the extent that action has already been taken in reliance on this authorization.

2. Information to be Released:

- ■ Complete Medical Record
- ■ Billing Information
- ■ Laboratory Reports
- ■ Imaging Reports
- ■ Other (specify): _____

3. Purpose of Disclosure:

- ■ At the request of the individual
- ■ Continuing Healthcare
- ■ Legal Purposes
- ■ Insurance
- ■ Other (specify): _____

4. Recipient(s) of Information:

Name: _____

Address: _____

Phone Number: _____

5. Expiration and Revocation:

This authorization shall remain in effect until revoked by me in writing, or until the following date or event, whichever occurs first: _____ I understand that revocation must be submitted in writing to the releasing entity and will not affect any disclosures made prior to receipt of the revocation.

6. Acknowledgment and Signature:

I acknowledge that I have read and understand this authorization form and that the information released may include information related to communicable diseases, mental health, drug and alcohol abuse, or genetic testing. I authorize the release of this information as described above.

Signature of Patient/Client: _____

Printed Name: _____

Relationship to Patient (if not patient): _____

7. Witness (if required):

• I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations. • This authorization is voluntary and refusal to sign will not affect my ability to obtain treatment, payment, or enrollment in a health plan unless allowed by law. • I may inspect or copy the information to be used or disclosed as permitted by law.

9. For Office Use Only:

Processed by: _____

Date: _____

Notes:

_____

_____

PATIENT/CLIENT SIGNATURE

Signature: _____

WITNESS SIGNATURE

Signature: _____