

# AUTHORIZATION FOR RELEASE OF INFORMATION

## Section A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Name: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

SSN#: \_\_\_\_\_

Persons/Organizations providing the information:

Persons/Organizations receiving the information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Specific description of information (including date(s)):

\_\_\_\_\_  
\_\_\_\_\_

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## Section B: Must be completed only if a health plan or health care provider has requested the authorization.

The health plan or health care provider must complete the following:

- \* What is the purpose of the use or disclosure? \_\_\_\_\_
- \* Will the health plan or care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above?  yes  no

The patient or the patient's representative must read and initial the following statements:

- \* I understand that my health care and the payment for my health care will not be affected if I do not sign this form. \_\_\_\_\_ **Initials**
- \* I understand that I may see and copy the information described on this form if I ask for it and that I get a copy of this form after I sign it. Further, I understand there may be a fee for a copy of this information. \_\_\_\_\_ **Initials**

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## Section C: Must be completed for all authorizations

The patient or the patient's representative must read and initial the following statements:

- \* I understand that this authorization will expire on \_\_\_\_/\_\_\_\_/\_\_\_\_. \_\_\_\_\_ **Initials**
- \* I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it will not have any effect on any actions they took before they received the revocation. \_\_\_\_\_ **Initials**
- \* I understand there may be a fee for copying and releasing my records, and that such fee is in accordance with state and federal guidelines. \_\_\_\_\_ **Initials**
- \* I understand that my records are protected under state and federal law. I understand that specific information to be disclosed may include history of drug or alcohol abuse, mental health treatment, AIDS or any other medical information. \_\_\_\_\_ **Initials**

\_\_\_\_\_  
Signature of patient or patient's representative  
(Form MUST be completed before signing)

\_\_\_\_\_  
Date

Printed Name of patient's representative: \_\_\_\_\_

Relationship to the patient: \_\_\_\_\_