AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ **Date of Birth**: _____

Address: _____ **City/State/Zip**: _____

Please note: Copy Fee May Be Charged For Medical Records

Please print and complete form

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name _____ Facility Phone: _____
Address: _____
City/State/Zip _____

Type of Information to disclose: ___Immunizations ___Most Recent 3 years ___Other_____

The purpose of disclosure is: ___Change of insurance ___Change of Physician ___Referral ___Other_____

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release to: _____

Address: _____

City, State, Zip: _____

Fax: _____ Phone: _____

I understand I may revoke this authorization at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization. **Unless otherwise specified or revoked, this authorization will expire 1 year from the date signed, or if I am a minor, on the date I turn 18 years of age.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

X_____ _____

Signature of Patient or Authorized Personal Representative — Date

_____ _____

Printed name of Authorized Representative — Relationship to Patient

_____

Address and telephone number of authorized representative
