

**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

**Please note: Copy Fee May Be Charged For Medical Records**

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.

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**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

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