AUTHORIZATION TO RELEASE HEALTH INFORMATION

This form authorizes _____ to use and disclose the health information of the patient for the purpose described below.
(Name of Practice)

Patient Name: _____
(Last) (First) (Middle Initial)

Date of Birth: _____ **Primary Contact Number:** (___) _____
☐ Home ☐ Cell ☐ Work

Mailing Address: _____
(Street)

_____
(City) (State) (Zip)

RECEIPIENT(S): This practice may disclose the information checked below to the following persons or entities, or classes/categories of persons or entities for the purpose indicated on this form.

Name: _____

Contact Person/Department: _____ Phone: (___) _____

Mailing Address: _____
(Street)

_____
(City) (State) (Zip)

CHECK THE TYPE(S) OF INFORMATION TO BE USED AND/OR DISCLOSED:

☐ Entire record ☐ Financial/insurance records ☐ Office visit notes ☐ Psychotherapy Notes*

*If psychotherapy notes are requested no other boxes can be checked/other records can be requested with this form.

☐ Lab/diagnostic results related to: _____ ☐ Records from: _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy)

☐ Records specific to a certain condition/treatment: _____

☐ Other (describe): _____

Photos & Multimedia: ☐ Photo received from patient or personal representative ☐ Photo taken by staff (e.g., pre/post procedure) ☐ Other clinical images (e.g., X-ray) ☐ Other: _____

Photos/Images may be posted: ☐ In Office ☐ On website ☐ Other: _____

Do not include:

☐ Mental health records ☐ Communicable diseases (including HIV/AIDS) ☐ Alcohol/drug abuse treatment

FORMAT/DELIVERY (IF APPLICABLE)

☐ Paper/mail ☐ USB/CD-ROM ☐ Encrypted Email: _____

☐ Secure Portal (name): _____ ☐ Other: _____

Transmission must meet HIPAA security standards. Security risk cannot be waived by patient.

(continued on back)

PURPOSE FOR THE USE OR RELEASE:

_____

_____

☐ This practice will receive direct or indirect payment because of this authorization (marketing or fundraising).

☐ This practice will receive direct or indirect payment that is more than the usual cost-based fee to prepare and transmit the information for this purpose – or other fee specifically permitted by law (typical for a sale of PHI).

EXPIRATION DATE OR EVENT

☐ One-time use/disclosure of information ☐ This information may be used/disclosed until: _____ mm/dd/yyyy

☐ Release this information until the end of a treatment or other event (e.g., research study):

_____

PATIENT RIGHTS

- You have the right to revoke/stop this authorization at any time in writing. Exceptions to this are listed in our Notice of Privacy Practices. A revocation/termination does not apply to releases of information that took place before the written revocation/termination was received by this practice.
- Information used or disclosed as permitted by this authorization may be redisclosed by the recipient and no longer protected by federal or state law.
- You have the right to refuse to sign this authorization. You are not required to sign this authorization in order to receive treatment from this practice.
- You understand PHI to be released may include a communicable disease diagnosis such as HIV or a diagnosis related to mental health or substance abuse unless it is excluded above.

_____ _____

Patient or Personal Representative Signature Date mm/dd/yyyy

Printed name and description of Personal Representative's Authority (attach necessary documentation if not already provided)

_____

FOR OFFICE USE & REFERENCE ONLY

☐ This authorization has been revoked: _____ mm/dd/yyyy

The revocation/cancellation must be in writing and filed with the original authorization.

Date original signed authorization received: _____ mm/dd/yyyy

Use/Disclosure/Release date: _____ mm/dd/yyyy

Fee charged: _____ ☐ Copy provided to patient/personal representative

Notes: _____

_____

_____