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**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

**I hereby authorize the use or disclosure of information from the medical records of:**

Patient Name: \_\_\_\_\_ Medical Record # \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Social Security # \_\_\_\_\_ (optional)

**I authorize the following individual or organization to disclose the above named individual's health information:**

\_\_\_\_\_ Address: \_\_\_\_\_

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

\_\_\_\_\_ Address: \_\_\_\_\_

**For the purpose of:**

**Please release the following:**

- Entire Record
- or:**  Problem List  X-Ray/Imaging Reports-from (date) \_\_\_\_\_ to (date) \_\_\_\_\_
- Progress Notes  X-Ray Films
- History/Physical Exam  Laboratory Results-from (date) \_\_\_\_\_ to (date) \_\_\_\_\_
- Medical List  EKG Reports
- Immunization Record  Genetic Testing Information
- List of Allergies  Other Diagnostic Reports (Specify) \_\_\_\_\_
- Other (Specify) \_\_\_\_\_

I understand that the information in my health record may include information relating to sexually transmitted diseases, 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.

**Yes**, I consent to the release of this information.  **No**, I do not consent to the release of this information.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.  
 I understand that I have the right to revoke this authorization at any time. I understand that I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization expires upon completion of this request or upon the following date: \_\_\_\_\_.

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 ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. 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. If I have questions about disclosure of my health information, I can contact \_\_\_\_\_ (*insert privacy officer or other office or individual name contact information*)

\_\_\_\_\_  
 Signature of Patient or Legal Representative

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Relationship to Patient (If Legal Representative)

\_\_\_\_\_  
 Witness