

# AUTHORIZATION FOR RELEASE OF INFORMATION

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Section A: Must be completed by patient or patient's representative for all authorizations.

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

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

I hereby authorize \_\_\_\_\_

(name of physician, hospital or health care provider)

to release my personal health and medical information as described below to the following person(s) or health care provider(s).

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

Information to be disclosed:

- Complete health record(s)
- Progress notes
- Laboratory/radiology tests
- Hospital record(s)
- History and physical examination
- Consultation reports
- Other (please specify) \_\_\_\_\_

Covering the period(s) of health care from (date) \_\_\_\_\_ to (date) \_\_\_\_\_

I understand that this will include information relating to:

- a) Acquired immunodeficiency syndrome (AIDS) or infection with human immunodeficiency virus (HIV)
  - b) Behavioral health services/psychiatric care
  - c) Diagnosis/treatment for alcohol and/or drug abuse
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- ✓ I understand that this authorization is voluntary.
- ✓ I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.
- ✓ I understand that I may inspect or receive a copy of the information described on this form if I ask for it.
- ✓ Unless otherwise cancelled, I understand that this authorization will expire one (1) year from this authorization.
- ✓ I understand that I may cancel this authorization at any time by notifying the providing health care provider in writing, but if I do, it won't have any effect on actions taken prior to receipt of the cancellation.
- ✓ I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the released information may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations. The recipient may otherwise be prohibited under federal law from re-disclosing substance abuse information, AIDS/HIV status, or mental health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Section B: This section must be completed only if a health plan or a health care provider has requested the authorization; the requesting party must complete this section.

1. The health plan or health care provider must complete the following:
    - a. What is the purpose of the use of disclosure? \_\_\_\_\_
    - b. Will the health plan or health care provider requesting the authorization receive financial compensation in exchange for using or disclosing the health information described above? (circle one)
      - YES
      - NO
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\_\_\_\_\_  
Signature of patient/parent/guardian/patient representative

\_\_\_\_\_  
Date

**REPRESENTATIVE**

If signed by other than patient, indicate relationship: \_\_\_\_\_

Address of patient's representative: \_\_\_\_\_

Telephone number of patient's representative: \_\_\_\_\_

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

**WITNESS NEEDED IF A REPRESENTATIVE SIGNS**

Witness: \_\_\_\_\_  
Signature

\_\_\_\_\_ Date