

AUTHORIZATION TO RELEASE INFORMATION

Patient Name:

Patient Address:

Medical Record #:

Date Of Birth: MM / DD / YY

Other Identifier (Social Security Number):

"I hereby authorize this practice to make uses and disclosure of my protected health information (information about me in my medical records and/or financial records) as indicated below."

THIS INFORMATION IS TO BE DISCLOSED TO:

Name of Entity:

Attention of:

Street Address of Entity:

City:

State:

Zip:

DESCRIPTION OF INFORMATION TO BE DISCLOSED:

REASON FOR REQUESTED USE OR DISCLOSURE:

TO BE READ AND SIGNED BY PATIENT:

I understand the following:

- a. I may revoke this authorization at any time by providing written notice to the practice
- b. I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance coverage
- c. The practice will not condition treatment or payment based on my signing this authorization
- d. I am signing this authorization freely
- e. No one has pressured me to sign this authorization
- f. The information disclosed in this authorization may be subject to redisclosure by the practice and no longer protected by federal law
- g. I acknowledge that I have had an opportunity to review this authorization and understand the intent and the use.
- h. I have received a copy of this authorization.

Patient Signature:

Date:

Signature Of Patient's Representative:

Relationship:

Date:

FOR OFFICE USE ONLY

Event or Date Upon Which Authorization Will Expire: