AUTHORIZATION FOR RELEASE OF INFORMATION

Section A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my health information as described below. I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

Patient name:______________________________ **Social Security Number:**________________________

Persons/organizations providing the information:

____
____
____
____

Persons/organizations receiving the information:

____
____
____
____

Specific description of information including date(s). If none noted, all records will be sent:_______________
____
____

If applicable, your medical records may include references to Mental Health Information, STD information including HIV Results, or Substance Abuse. Please let us know if you do not want this information released.

____

What is the purpose of the use or disclosure?:____
____

(**Note**: "at the request of the individual" is a sufficient description of the purpose when the patient initiates the authorization and elects not to provide a statement of the purpose.)

Section B: Must be completed only if the healthcare provider has requested the authorization

1. The provider must complete the following statement:
   a. Will the healthcare provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes______ No______
2. The patient must read and initial the following statement:
   a. I understand that I get a copy of this form after I sign it. Pt. initials:________

Section C: Must be completed for all authorizations

I understand that I have the right to refuse to sign this form and that my refusal will not result in the physician conditioning the provision of Healthcare with two exceptions: **1.** Refusal to sign this authorization, if it is for disclosure of information created for research that includes treatment, may result in the physician declining to provide the research-related treatment. **2.** Refusal to sign this authorization, if it is for disclosure of information created for the sole purpose of disclosure to a third party, may result in the doctor declining to provide the healthcare which is for the sole purpose of creating protected health information for disclosure to a third party. Pt. initials:_________

I understand that this authorization will expire on the following date___/___/____(MM/DD/YY) or with the following event: ____. If none noted, then one year from the date of signature.

I understand that I may revoke this authorization at any time by notifying the healthcare provider in writing with the form provided to me. The revocation will only be effective from the date it is received in this office and will not apply retroactively. Pt. initials:_________

____ ______________________

Signature of patient or patient's representative **Date**

(pertinent sections of the Form MUST be completed before signing.)

Printed name of patient's representative:____

Relationship to the patient:____