



Authorization for the Release of Medical Information

Patient Name:	Phone Number:
Patient Address: Street, City, State, Zip	
Date of Birth:	Mm dd yr
Other identifier (social security number):	

I hereby authorize _____ [health care provider] to disclose or transfer my protected health information as indicated below.

This information is to be disclosed to: Name: Attention of: Street Address: City, State, Zip
DESCRIPTION OF INFORMATION TO BE DISCLOSED: For dates of treatment from _____ to _____ REASON FOR REQUESTED USE OR DISCLOSURE: <input type="checkbox"/> Transfer of health coverage <input type="checkbox"/> Personal use <input type="checkbox"/> Form completion <input type="checkbox"/> Referral <input type="checkbox"/> Change in health care provider <input type="checkbox"/> Other This authorization expires in one year from the date signed or earlier _____ <p style="text-align: right;">date</p>

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 disclosing provider will not condition treatment or payment based on my signing this authorization.
 - d. I am signing this authorization freely and under no pressure from any individual to do so.
 - e. The information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA or other privacy laws.
 - f. I acknowledge that I have had an opportunity to review this authorization and understand its intent and use.
 - g. I will receive a copy of this completed and signed authorization form.

There will be a charge of 75 cents per page for copying medical records plus cost of mailing.

Patient Signature:	Date:
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