



AUTHORIZATION TO RELEASE HEALTH INFORMATION

NAME: _____ DOB: _____ Phone #: _____

PLEASE OBTAIN INFORMATION FROM:

PLEASE SEND INFORMATION TO:

Name of Provider/Clinic/Organization

Name of Provider/Clinic/Organization

Street Address

Street Address

City, State, Zip Code

City, State, Zip Code

Phone _____ Fax _____

Phone _____ Fax _____

I AUTHORIZE the following information to be disclosed: (Please initial all that apply)

___ Entire record ___ Billing records ___ Lab tests
___ Radiology reports ___ Other

Date(s) of records to be released: _____

REASON for disclosure of health information: (Please initial)

___ At my request ___ Job ___ Other:
___ Continuing care ___ School
___ Legal ___ Insurance

EXPIRATION of this Authorization: (Please initial one)

___ 90 days after signature date ___ On this date:
___ When this event happens: _____

ADDITIONAL PATIENT INFORMATION:

- I understand that I do not have to sign this authorization to get treatment.
- I understand that I have a right to withdraw this authorization at any time. To withdraw, please sign below.
- I understand that signing this authorization does not negate any rights I have under other state or federal laws.
- I understand that once my health care information is disclosed as I have authorized, it could be redisclosed by the recipient and is no longer protected.

Patient Signature (Parent or legal representative, if applicable) Date

I wish to withdraw this authorization- Patient Signature Date

___ Pick up records ___ Mail Records ___ FAX Records