AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

Patient Name _____ Date of Birth _____

Patient Address _____

Patient Phone Number _____ Previous Name _____

INFORMATION TO BE RELEASED BY:	INFORMATION TO BE RELEASED TO:
Dr /Clinic _____	Dr / Clinic _____
Address _____	Address _____
_____	_____
Phone _____	Phone _____
Fax _____	Fax _____

I authorize the professional office named above to release health information identifying me (which may include information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services) under the following terms and conditions:

1. **Detailed description of the information to be released:**
   - ❑ Most recent visit
   - ❑ Health care information related to the following treatment or condition: _____
   - ❑ Health care information in my medical record for the date(s): _____
2. **Reason(s) for this authorization (check all that apply):**
   - ❑ At Patient's Request. ☐ At doctor's request. Other: _____
3. **Expiration date of this Authorization:**
   - ❑ 90 days from the date signed (Authorization will expire in 90 days if not otherwise specified.)
   - ❑ On (date: mm/dd/yyyy): _____
   - ❑ When the following event occurs: _____

I understand that I do not have to sign this authorization form in order to receive health care benefit (treatment, payment, enrollment, or eligibility for benefits). However, I do have to sign this authorization form to receive health care when the sole purpose of the health care is to create information for a third party, or to take part in a research study.

I can revoke this authorization later. I understand that: 1) I must revoke my authorization in writing; 2) If I revoke my authorization, it will not affect any actions already taken based upon this authorization; and 3) I may not be able to revoke this authorization if the purpose of it was to obtain insurance.

Once disclosed, health care information may be subject to redisclosure by the recipient in which privacy laws may no longer protect the information. I understand that this authorization does not permit the release of information related to health care provided to me more than ninety days after the date of this authorization. This prohibition does not extend to insurance companies.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

PATIENT SIGNATURE _____ **DATE** _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____ Print Name _____

Source of Authority _____