Patient Authorization for Disclosure of Protected Health Information

Patient: Legal Name: ____

Date of Birth: ____

Provider Releasing Information: Name: ____

Address/Phone/Fax: ____

____

Release Information:

- ☐ Complete Medical Record
- ☐ Medical Records for Past Year
- ☐ Other Records ____

Purpose: ____

I specifically authorize the release of data and information relating to (check all that apply):

- ☐ Mental Health Records
- ☐ HIV/AIDS test results
- ☐ Sexually Transmitted Diseases

Information Sent To: (Name) ____

(Address) ____

(Phone) _____________________________ (Fax) _________________________

Revocation: I understand that I may revoke this authorization at any time by notifying my physician in writing. I understand that if I revoke this authorization, it will not affect any actions that my physician took before my revocation letter was received.

A faxed or photocopy of this authorization shall be considered valid as the original.

This authorization is effective for one year from the date on which it was signed.

____ ______________

Signature of patient (or parent/legal guardian if under age 19) Date