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Authorization for Release of Medical Information

I hereby authorize use and/or disclosure of protected health information (PHI) about me as described below. By signing, I authorize the above mentioned physicians to receive certain PHI about me from:

Provider/Specialty: ____ **Phone:** _________________________

Address: ____ **Fax:** ___________________________

Provider/Specialty: ____ **Phone:** _________________________

Address: ____ **Fax:** ___________________________

Provider/Specialty: ____ **Phone:** _________________________

Address: ____ **Fax:** ___________________________

____ The contents of my medical records, laboratory data, EKG/x-ray, prescriptions.

____ The contents of my medical file consisting of mental health records.

____ Hospital discharge summary, cardiac tests, labs and x-rays. When/Where: ________________________________

_____ Other: ______________________________________

The information will be used or disclosed for the following purposes:

____ To aid in the diagnosis and/or continuing treatment of the patient.

____ At the request of the individual.

____ Other (please specify):

____

I understand that if the person or organization authorized to receive the information is not a health plan or healthcare provider; the released information may no longer be protected by federal privacy regulations.

I may revoke this authorization by notifying the provider named above in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to who this authorization is furnished may not condition its treatment of me on whether or not I sign it.

This authorization expires one year from today _____________________, 20_____, unless specified otherwise by me to the provider.

THIS FORM MUST BE COMPLETED BEFORE SIGNING

____ ____

Print Patient's Name | Date of Birth

____ ____

Patient or Legal Guardian Signature | Date

Patient/Legal Guardian must be provided with a copy of this form.