AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize _____
(Entity/Person from Whom Records are Requested)

_____
(Full and Complete Address)

_____
(Phone Number and Fax Number Helpful, if available)

to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider; the released information may no longer be protected by federal and state privacy regulations.

_____
Print Patient Name Date of Birth Social Security Number

Date(s) of service (if known): _____

Description of information to be released: (check all that apply)

____ Emergency Room
____ History & Physical
____ Nurse's notes
____ Progress notes
____ Discharge summary

____ Radiology reports
____ Consultation reports
____ Physician's orders
____ Operative records
____ Radiology films

____ Admission/Registration records
____ Laboratory reports
____ Billing records

____ Other: _____
_____
_____
_____

Description of the purpose of the use and/or disclosure: _____
_____

The health information described herein shall be released to: ___Hospital; __X__ **Physician**;
____ Insurance Company; ___ Attorney; ___ Patient; ___ Other (Check the appropriate category)

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I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until_____.
expiration event/date

I further understand that I may revoke this authorization at any time by notifying (Person/Entity from Whom Records are Requested) _____ in writing at (address) _____. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

_____ _____
Signature of Patient or Patient's Representative Date

_____
Printed name of Patient's Representative

_____ _____
Relationship to Patient or Legal Authority (attach supporting documentation)