

# Authorization To Disclose Health Information

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Social Security # \_\_\_\_\_ (optional)

I authorize the following individual or organization to disclose the above named individuals health information:

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax # \_\_\_\_\_

This information may be disclosed TO and used by the following individual or organization:

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

For the purpose of: \_\_\_\_\_

Please release the following:

\_\_\_\_ Entire Record

Or: \_\_\_\_ Problem List

\_\_\_\_ Progress Notes

\_\_\_\_ History/Physical Exam

\_\_\_\_ Medication List

\_\_\_\_ List of Allergies

\_\_\_\_ X-Ray/Imaging Reports-from (date) \_\_\_\_\_

\_\_\_\_ Laboratory Results-from (date) \_\_\_\_\_

\_\_\_\_ Operative Reports-from (date) \_\_\_\_\_

\_\_\_\_ Other (specify) \_\_\_\_\_

I understand that the information in my health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). \_\_\_\_ **Yes, I consent to the release of this information** \_\_\_\_ **No, I do not consent to the release of this information.**

I understand that the information released is for the specific purpose stated above. Any other of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization expires upon completion of this request or upon the following date:

\_\_\_\_\_.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient (If Legal Representative)

\_\_\_\_\_  
Witness

## COMPLETE ONLY IF INFORMATION IS TO BE RELEASED TO PATIENT:

I understand that my medical record may contain reports; test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold \_\_\_\_\_ liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient (If Legal Representative)

\_\_\_\_\_  
Witness

Date request completed \_\_\_\_\_ # of pages copied \_\_\_\_\_ Initials \_\_\_\_\_