PATIENT AUTHORIZATION TO RELEASE INFORMATION

FIRST NAME M.I. LAST NAME

MAILING ADDRESS

CITY STATE ZIP CODE

HOME PHONE (Include Area Code) WORK PHONE (Include Area Code)

__________-______-__________ _______/_______/_________

SOCIAL SECURITY NUMBER DATE OF BIRTH

I hereby authorize this practice to make uses and disclosures of my protected health information about me that is documented in my medical and/or financial records as indicated below:

Describe the information you are requesting and authorizing our office to release:____________________

Describe the purpose of this authorization to release information:____________________

RELEASE MY INFORMATION TO:____________________

COMPLETE MAILING ADDRESS:____________________

CITY:____________STATE:__________ZIP CODE:______-____

EXPIRATION OF AUTHORZATION

This authorization expires on:____,____,____or when the following event occurs:________

RESTRICTION INFORMATION

The patient may refuse to sign this information because: (*check box that applies*)

- ☐ The services covered by this authorization ARE RELATED TO TREATMENT of an injury, illness or condition. Therefore, WE CANNOT REFUSE SERVICES if you choose not to sign this authorization. However, failure to sign the authorization may prohibit us from releasing the information you requested.
- ☐ The services covered by this authorization ARE NOT RELATED TO TREATMENT of an injury, illness or condition. Therefore, WE CAN REFUSE SERVICES if you choose not to sign this authorization.

The person making this authorization may revoke (cancel) authorization at any time. The cancellation must be in writing (see below). This cancellation will be effective upon receipt, but will not apply to any disclosure of health information that we made before we received the cancellation notice.

The information that we release may be subject to re-disclosure by the person that receives it. If this happens, the Federal Privacy Standards will no longer protect the information.

Patient's Signature: Patient's Printed Name: Date Signed

Representative's Signature: Representative's Printed Name: Date Signed

Please describe your authority to act on the patient's behalf:____________________

FOR INTERNAL OFFICE USE ONLY: ☐ REVOCATION ☐ FAILURE TO SIGN ☐ REASON:________________