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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

SECTION A: Must be completed for all authorizations
I hereby authorize the use or disclosure of my health information as described below. I understand the information disclosed pursuai to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

PATIENT NAME: _____

DOB: _____/_____/_____ SOCIAL SECURITY #:_____-_____-_____

Persons / organizations PROVIDING the information:

_____

_____

_____

_____

Persons / organizations RECEIVING the information:

_____

_____

_____

_____

Specific description of information to be released (including date / dates): _____

_____

_____

What is the reason for releasing this information? _____

_____

_____

(NOTE: "AT THE REQUEST OF THE INDIVIDUAL" IS A SUFFICIENT DESCRIPTION OF THE PURPOSE WHEN THE PATIENT INITIATES THE AUTHORIZATION AND ELECTS NOT TO PROVIDE A STATEMENT OF THE PURPOSE.)

SECTION B; MUST BE COMPLETED ONLY IF THE HEALTHCARE PROVIDER HAS REQUESTED THE AUTHORIZATION

1. **The provider must complete the following statement:**
   a. **Will the healthcare provider requesting the authorization receive financial or in-kind compensation in exchange for or disclosing the health information described above YES_____ NO_____**

2. **The patient must read and initial the following statement:**
   a. **I understand that I get a copy of this form after I sign it. Patient initials: _____**

SECTION C: MUST BE COMPLETED FOR ALL AUTHORIZATIONS

I understand that I have the right to refuse to sign this for m and that my refusal will not result in the physician conditioning the provision of Healthcare with two exceptions:

1. Refusal to sign this authorization, if it is for disclosure of information created for research that includes treatment, may result in the physician declining to provide the research-related treatment.

2. Refusal to sign this authorization, if it is for disclosure of information created for the sole purpose of disclosure to a third party, may result in the doctor declining to provide the healthcare which is for the sole purpose of creating protected health information for disclosure to a third party.
Patients initials: _____

I understand that this authorization will expire on the following date_____/_____/_____ **(MM/DD/YR)** or with the following event:

_____

I understand that I may revoke this authorization at any time by notifying the healthcare provider in writing. The revocation will only be effective from the date it is received in this office and will not apply retroactively. Patient initials: _____

_____ _____

Signature of patient or patient's representative **Date**
*(pertinent sections of this form **MUST** be completed before signing)*

Printed name of patient's representative: _____ **Relationship:** _____