AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize _____ (the "Covered Entity") to disclose my individually identifiable health information as described below. I understand that this authorization is voluntary and I may refuse to sign it. I also understand that my healthcare and the payment of my healthcare will not be affected if I do not sign this form. Finally, I understand that if the recipient I authorize to receive the information is not a covered entity, the released information may no longer be protected by federal and state privacy regulations.

Name of Patient/Individual (Please Print) | DOB | Phone | E-Mail (Optional)

Street | City | State | Zip

I AUTHORIZE THE COVERED ENTITY TO DISCLOSE THE PATIENT/INDIVIDUAL'S PHI TO:

Person/Organization | Phone | Fax

Street | City | State | Zip

REASON FOR DISCLOSURE:

☐ Treatment/Continuing Medical Care	☐ Legal Purposes	☐ Employment
☐ Personal Use	☐ Disability Determination	☐ At the Request of the Patient/Individual
☐ Billing or Claims / Insurance	☐ School	☐ Other: _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. If all health information is to be released, then check only the first box – "*All Health Information*"

☐ Specific Dates of Services:

_____

OR

☐ All Date of Services

☐ All Health Information
☐ Patient History
☐ Progress Notes
☐ Past/Present Medications
☐ Diagnostic Test Reports
☐ Billing Information
☐ Other: _____

Your initials are required to release the following information:

_____ Mental Health Records (excluding psychotherapy notes[1])
_____ Drug, Alcohol, or Substance Abuse Records
_____ Genetic Information
_____ HIV / AIDS Test Results or Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of: the occurrence of the death of the individual; the individual reaching the age of majority; permission is withdrawn; or the following specific date (optional): _____

RIGHT TO REVOKE. I understand that I have the right to revoke this authorization, in writing, at any time, except to the extent that Covered Entity has taken action in reliance on it. My revocation is effective when Covered Entity received my written request.

NOTICE OF PRIVACY PRACTICES. By signing this authorization, I acknowledge that I have been provided a copy of, have read, and understand the Covered Entity's Notice of Privacy Practices containing a complete description of my rights, and the permitted uses and disclosures, under HIPAA.

Signature of Patient, Parent, or Legal Guardian | Printed Name of Patient, Parent, or Legal Guardian | Date

Relationship to Patient **OR** Legal Authority (Attach Supporting Documents)

*In addition to Parent / Legal Guardian, a minor's signature is required for the release of certain types of information, including the release of information related to certain types of reproductive care, sexually transmitted diseases, drug, alcohol or substance abuse, and mental health treatment.

Signature of Minor Patient (If Applicable)

[1] *An authorization for use or disclosure of psychotherapy notes may not be combined with authorization for release of other PHI. A separate authorization is required.*