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AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Full Name: _____ Date of Birth: _____

Name When Treated (if different from above): _____

Treatment Dates: _____

I. My Authorization

Please release the following information: (check all that apply)

- ☐ HIV/AIDS Testing and/or Treatment
- ☐ Alcohol and/or Drug Treatment
- ☐ Medical Evaluation
- ☐ Medical Progress Notes
- ☐ Laboratory Test Results
- ☐ Medication Information
- ☐ Psychiatric Evaluation
- ☐ Psychiatric Progress Notes
- ☐ Psychotherapy Notes
- ☐ Summary of Care
- ☐ Financial Information
- ☐ Re-disclosure of Information Received From Outside Sources

This information is to be disclosed from: _____
Provider Name and Phone # - or - Patient Name

This information is to be disclosed to: _____
Provider Name and Phone # - or - Providing info to parent, etc.

The reason for this authorization is: _____

This authorization ends when revoked by the patient or the patient's representative in writing.

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form to receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. This authorization may be revoked by writing a letter to the office. Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____
Patient or Legally Authorized Individual Signature — Date

_____ _____
Printed Name if Signed on Behalf of the Patient — Relationship to patient