

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

Patient's Name: \_\_\_\_\_  
(please print clearly)

Local Phone: \_\_\_\_\_

CC ID# \_\_\_\_\_

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

**Release records from:**

**Release records to:**

Name: \_\_\_\_\_

Name: \_\_\_\_\_

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

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

City, State, Zip: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

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

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

I request and authorize \_\_\_\_\_ to release the information specified below to the agency, organization or individuals named on this request. *(Check all that apply)*

- Complete Health Records
- Laboratory Tests
- Progress Notes
- Consultation Reports
- Other (please specify): \_\_\_\_\_

**Covering the period of health care:**

From (date): \_\_\_\_\_ To (date): \_\_\_\_\_

The reason I am requesting this information is: \_\_\_\_\_

I request and authorize \_\_\_\_\_ to release the following information to the agency, organization or individual names designated on this request.

- Drug or alcohol abuse, or history of, if any.
- Information regarding HIV and / or HIV test results.
- Psychological or psychiatric conditions, or history of, if any.
- Information regarding learning disability and / or attention deficit disorder, if any.

**Patient rights:**

I certify that this request has been made voluntarily. I understand that information about my case is confidential and protected by state and federal law. I understand that this authorization will **EXPIRE 180 DAYS** from the date of my signature. I may revoke this authorization by writing a letter to the releasing office/health center. 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.

Once the office/health center discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it. I understand what this agreement means, and that I am entitled to a copy of this form. A copy or fax of this release is as valid as the original.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date