AUTHORIZATION TO USE AND/OR DISCLOSE MEDICAL RECORDS

I give authorization to the provider listed below to disclose a copy of the specific health/medical information identified below:

NAME OF PATIENT			
DATE OF BIRTH		SS#	

TO: (Name, Address, Phone of **Recipient** of Records)			
Name		Phone	
Address		Fax	
City and State		Zip	

RECORDS FROM: (Who is **Releasing** the Records)			
Name		Phone	
Address		Fax	
City and State		Zip	

For the Following Purposes:

	Continued Medical Care		Personal Information		Legal follow-Up
	Disability Insurance		Other:		

By Checking the Boxes Below, I Specifically Authorize the Use and/or Disclosure of the Following Health Information and/or Medical Records, If Such Information and/or Records Exist:

	Please send the entire Medical Record (all Information) to the above named recipient.				
	Office Notes and Reports		Diagnostic Reports		Billing Statements
	Rx History		Laboratory Reports		Prenatal Record
	Others Listed Here:				

The Following Items Must Be Initialed to Be Included in the Use and/or Disclosure:

____ HIV/AIDS related information and/or HBV, TB or Other Communicable Diseases
____ Mental Health Information and/or Records
____ Domestic Violence
____ Genetic Testing Information and/or Records
____ Drug/Alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information to be disclosed.) Describe: _____
____ Other: _____

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by HIPAA and other federal and state regulations. However, the recipient may be prohibited from disclosing the substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
I also understand that the person I am authorizing to use and/or disclose the information may not receive compensation for doing so.
I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment of my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization.
Finally, I understand that **I may revoke this authorization**, in writing, at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless Revoked Earlier, this Authorization Will Expire in Six (6) Months from the Date of Signing or until (Insert Date):_____

Print Patient's Name: _____ Date: _____

Signature of Patient or Patient's Legal Representative: _____

Print Name of Legal Representative (if applicable):_____

Relationship to patient: _____

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