AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Information:

Name of Patient: _____ Date of Birth _____

Address: _____ City, State, ZIP: _____

Phone: _____

At my request the following information may be released:

○ Entire Record ○ Financial Records ○ Marketing* ○ Office Visit Notes
○ On site record review by the patient ○ Diagnostic Studies (list):
○ Psychotherapy notes – if this box is checked; only psychotherapy notes will be releases.
○ Others as listed:

*Financial compensation is received for this communication.

Entity or person who will receive the information:

Name: _____

Address: _____

City, State, ZIP: _____ Phone: _____

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

Patient Rights:

- I have the right to revoke this authorization at any time..
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

I understand that released information may include a communicable disease diagnosis such as HIV.

_____ Date: _____

Signature of Patient of Personal Representative

*Description of Personal Representative'e Authority (attach necessary documentation) REVISED August 2013

Authorization for Release of Information – Compound Release

Name of Patients _____ Date of Birth _____

_____ is authorized to release protected health information about the above named patient in the following manner and to identify persons.

Entity to Receive Information. Check each person/entity that you approve To receive information.	**Description of Information to be released.** Check each that can be given to person/entity in the Same section.
◯ Voice Mail	◯ Results of lab tests/x-rays OTHER: _____
◯ Spouse (provide name & phone number)	◯ Financial ◯ Medical
◯ Parent (provide name & phone number)	◯ Financial ◯ Medical
◯ Email communication – Provide email address** ◯ Financial ◯ Medical ◯ Breach Notification ** In order for email communication to occur, Please accept the disclosure below. Email Address: _____	
◯ For email communication I understand that if email is not sent in an encrypted manner, there is a risk it could be accessed inappropriately. I still elect to receive email communication.	
◯ Communication about treatment alternatives even in this office is being compensated for making communication.	

Patient Rights:

- I have the right to revoke this authorization at any time..
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

_____ Date: _____

Signature of Patient of Personal Representative

*Description of Personal Representative'e Authority (attach necessary documentation) REVISED August 2013