AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
(Confidentiality Agreement Not Required)

Patient Name: _____

Date of Birth: _____

Pt. Phone #: _____

Years of Service (if known): _____

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. **I hereby authorize:** _____
(Fill in name of individual, facility, or agency)

_____
(Fill in address) (Phone No.)

_____
(City, state, zip code) (Fax No.)

3. **To provide medical and/or psychiatric information to:**

_____
(Fill in name of individual, facility, or agency)

_____
(Fill in address) (Phone No.)

_____
(City, state, zip code) (Fax No.)

_____ Mutual exchange of PHI is authorized (e.g., telephone conversations, letters, etc.)

4. Indicate by your ***initials*** the information and time period that is to be disclosed:
From _____ to _____

____ History/Physical	____ Clinical Records (except psychotherapy notes)	
____ Lab Report(s)	____ Discharge Summary	____ Educational Records
____ Consultation(s)	____ Evaluations	____ Legal Records – specify
____ Other _____		_____

5. If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed only if I place my ***initials*** in the applicable space next to the type of information.

____ HIV/AIDS information	____ Genetic testing information
____ Mental health information	____ Drug/alcohol diagnosis, treatment, or referral information

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

I understand that there are inherent risks in the transmission of information through electronic media, and that reasonable precautions will be implemented to minimize risks.

6. This information for which I am authorizing disclosure will be used for the following purpose(s) (check those that apply):

   ____ Personal records ____ Patient care ____ Evaluation ____ Legal

   ____ Other (please describe) _____

7. You do not need to sign this authorization. Refusal to sign means you will not receive health care services if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

8. You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage.

   To revoke this authorization, please send a written statement to _____
   (Contact person) at _____
   (Address of person/entity disclosing information) and state that you are revoking this authorization.

I have read this authorization and I understand it. Unless revoked, this authorization expires on (Insert either applicable date or event).

By: _____ Date: _____
(Individual or personal representative)

Description of personal representative's authority: _____