[Name of Entity and Address]

AUTHORIZATION FOR RELEASE OF INFORMATION

Must be completed for all authorizations

I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient name: _____
Address: _____
_____
_____

Persons/Organizations providing the information:

_____
_____
_____
_____

Persons/organizations receiving the information's:

_____
_____
_____
_____

Specific description of information (including date(s)):

_____
_____
_____
_____

Must be completed for all authorizations

The patient or the patient's representative must read and initial the following statement:

1. I understand that this authorization will expire on ___/___/_____ (DD/MM/YYYY) Initials: _____
2. I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do it won't have any effect on any actions they took before they received the revocation. Initials_____

_____ _____

Signature of patient or patient's representative **Date**
(Form MUST be completed before signing)

Printed name of patient's representative: _____

Relationship to the patient: _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION
You may not use this form to release information for treatment or payment except
When the information to be released is psychotherapy notes or certain research information.