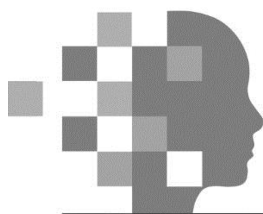

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

1. I hereby authorize____
   to use/disclose the protected health information described below to
   ____.

2. Description of information to be released:
   □ Medical □ Pathology/Laboratory □ Dental
   □ Mental Health □ Substance Abuse/Alcohol □ HIV
   □ Communicable Disease □ Psychotherapy Notes □ Genetic Testing
   □ Other (please specify):____

   For the following dates of service: from ________ (date) until ____________ (date).

3. Description of Purpose for the Use or Release of Information. Indicate how the information is to be used: □ Health Care □ Personal Use □ Legal
   □ Other (please specify):____

4. This authorization for release of the above information to the above-named persons/entity will expire on_____________ (date or event – if not specified it will expire in 180 days).

5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

6. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

7. I understand that information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by federal or state law.

____ _______________________

Signature of Patient or Personal Representative Patient Date of Birth

____ _______________________

Print Name of Patient or Personal Representative Date