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### AUTHORIZATION TO RECEIVE / RELEASE HEALTH INFORMATION A

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City / State / Zip \_\_\_\_\_

**I Hereby Authorize the Disclosure of my Health Information From:**

Name of Person/Organization Releasing Information	
Address	City / State / Zip
Phone Number // Fax Number	

**To Release my Information To:**

Name of Person/Organization Receiving Information	
Address	City / State / Zip
Phone Number // Fax Number	

**INFORMATION TO BE RELEASED:**

\_\_\_\_\_ Complete Medical Record  
\_\_\_\_\_ Medical Records for Specific Dates of Service (please list) from \_\_\_\_\_ to \_\_\_\_\_  
\_\_\_\_\_ Other (please list) \_\_\_\_\_

**This authorization remain in effect until the information has been forwarded as requested.**

**RIGHTS OF THE PATIENT:**

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. *Any information received by this office for our own use will continue to be protected by the Federal Privacy Rule (HIPPA).* I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document by written notification. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

X \_\_\_\_\_ X \_\_\_\_\_  
Printed Name of Patient or Personal Representative Signature of Patient or Personal Representative DATE

\_\_\_\_\_  
Description of Personal Representative's Authority (attach necessary documentation)

\*\*\*\*\*  
**Date Sent:** \_\_\_\_\_ **By:** \_\_\_\_\_ **Via:** \_\_\_\_\_