AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Patient Name _____ **Date of Birth** _____

Address _____

Phone _____

I herby authorize that the protected health information regarding the above-named person be forwarded:

From: Person/Institution _____

Address _____

Phone _____ Fax _____

To: Person/Institution _____

Address _____

Phone _____ Fax _____

Purpose or need for information: _____

Disclosure will include:

( ) Progress notes
( ) Pathology report
( ) Lab results
( ) Operative report
( ) Other _____
( ) Entire record

Restrictions: _____

If no restrictions are specified the health information released to the named recipient may include testing, diagnosis, evaluation and/or treatment for alcohol and/or drug abuse, HIV, mental, physical and/or emotional illness.

This Authorization is subject to revocation by the patient at any time in writing to the medical record contact person at this site of care except to the extent that action has already been taken to release this information. Unless revoked, this authorization will remain valid for 1 year after signing. Patient has the right to inspect a copy of the health information to be released and without the signature that information will not be released.

_____ _____

Signature of Patient **Date**

_____ _____

Signature of Parent/Legal Guardian **Signature of Witness**

REDISCLOSURE: Notice is hereby given to the Recipient receiving the requested health information that law prohibits the redisclosure of any health information regarding drug and/or alcohol abuse, HIV and mental treatment.