

Authorizing For Release of Information

Section A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my individual 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. This form must be **COMPLETELY** filled out.

Patients Name: _____ SSN: _____

Phone #: _____ DOB: _____

Organizations releasing information: _____ Organizations/Person receiving information: _____
Name: _____ Name: _____
Address: _____ Address: _____

Phone #: _____ Phone #: _____

Section B: Must be completed for all authorizations

For healthcare covering period(s)
From: _____ to _____ Or _____ All Records

May include other healthcare provider's records? _____ yes _____ no
May records be faxed or electronically transmitted? _____ yes _____ no

Section C: Must be completed and signed

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

_____ I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any affect on any actions they took before they received the revocation.
_____ I understand there will be a fee for copying and releasing my records, (\$25.00 for the first 25 pages, and 15 cents for each additional page) and that such fee is in accordance with state and federal guidelines.
_____ I understand that my records are protected under state and federal law. I understand that specific information to be disclosed may include history of drug or alcohol abuse, mental health treatment, AIDS, and all other medical information.

I understand and agree that my medical records will be maintained in a computerized medical information system and that records may be transmitted electronically via fax to medical providers or by US mail to patients.

Signature of patient or patient's representative _____ Date _____

Relationship to patient: _____