
[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

(Form MUST be completed before signing)

Date

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.**