AUTHORIZATION FOR RELEASE OF INFORMATION

Section A. Complete for All Authorizations

I hereby authorize the use or disclosure of my individually identifiable health information (PHI) as described below. I understand that this authorization is voluntary. I understand that, if the organization authorized to receive my PHI is not a health plan or health care provider, the released PHI may no longer be protected by federal privacy regulations.

Patient name:_____ ID Number:_____

Persons/organizations authorized to release your PHI

Persons/organizations authorized to receive your PHI

Specific description of PHI to be released (including date(s)): _____

Specific restrictions you want placed on release of your PHI:_____

I understand that this authorization will expire on - ___/___/___ (DD/MM/YR) Initials: _____

I understand that I may revoke this authorization at any time by notifying the releasing organization in writing, but my revocation will not affect any releases made or other actions taken before the date of my revocation. Initials: _____

Section B. Complete if Release is Requested by Health Care Provider

(To be Completed by Provider Before Signature by Patient)

_____ Request for Own Use _____ Request for Use and Disclosure by another Provider/Plan

The use or disclosure for which this request is made is _____

As the Provider, we will not receive financial or other compensation in exchange for using or disclosing the health information described above.

(To be Completed by Patient Before Signing)

I understand that I am not required to sign this authorization form Initials: _____

I understand that my health care and the payment for my health care will not be affected if I do not sign this form.

Initials: _____

I understand that I may see and copy the PHI to be released pursuant to this form if I so request, and that I will receive a copy of this form after I sign it. Initials: _____

Section C: Complete for All Authorizations

Signature of patient or patient's representative *(Form MUST be completed before signing.)* **Date**

Printed name of patient's representative:

Relationship to the patient:

This form is not necessary to release information for treatment or payment purposes except if the information to be released is psychotherapy notes or certain research information.