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Barcode

Authorization to Release Medical Information

Release From:

Agency/Name	Phone:	Fax:
Address:	**City:**	**State/Zip:**

Release To:

Agency/Name:	Phone:	Fax:
Address:	**City:**	**State/Zip:**

Purpose of Disclosure: ☐ Attorney ☐ Continuum of Care ☐ Personal ☐ Transfer of Care ☐ Testimony/Deposition

Information to be released: (Please check all that apply)

☐ Billing Records ☐ Radiology ☐ Lab and Pathology Reports ☐ Medical Records ☐ Dental ☐ Immunization

☐ All health care information (excluding sensitive information) for the last two years.

☐ Other: _____ Date Range: _____

INCLUDE the following: (Please check all that apply)

☐ HIV/AIDS diagnostic/treatment/testing ☐ Sexually Transmitted Infection ☐ Behavioral or Mental Health Service or Treatment

☐ Substance use/treatment/diagnostic/testing

Format: ☐ Paper ☐ Mail ☐ CD ☐ USB ☐ Transmit to Provider ☐ Communication Only

☐ Other _____

This Authorization is valid for: ☐ 30 days ☐ 90 days ☐ 180 days ☐ 1 year ☐ Expiration Date (mm/dd/yy) / /
(If left unselected, then expiration will occur one year from the date of this Authorization.)

Client Rights:
I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or healthcare operations) and that I may revoke this authorization in writing at any time. The revocation excludes any information previously released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

I understand that my substance use disorder records are protected under the federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 CFR, Part 2, and the Health Insurance Portability and Accountability Act of 1996, 45 CFR Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

Patient full name: _____DOB: _____

Address: _____

Phone: _____

Patient Signature: _____ Print Name: _____ Date: _____

Representative, Interpreter, or Witness (Please print): _____ Date: _____

Office Use Only (please check box) ☐ File in Chart Only ☐ Process-Send Records