# AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

**(All sections must be completed)**

Patient Name: _____ Date of Birth: _____

I hereby authorize _____ ("**Practice**") to disclose my protected health information ("**PHI**") to the person/entity stated herein for the following purpose ("at the request of the patient" is a sufficient description of the purpose when the patient initiates the authorization and elects not to provide a statement of the purpose):

_____

NAME OF PROVIDER OR PRACTICE TO RECEIVE PHI:

_____

The above individual person/entity may receive PHI via:

☐ Phone _____ ☐ Secure Portal _____
☐ Email _____ ☐ Fax _____
☐ Mail _____ ☐ Other _____

This Authorization applies to (check all applicable):

☐ All health information contained in my health care record.
☐ Health care information relating to the following treatment, condition or date(s) of treatment:

_____

_____

☐ Specific records to be released: _____

**Unless checked below, I understand the released information may include the following information. Check if you do *NOT* want to include:**

**☐ Substance /alcohol abuse treatment ☐ Mental health and developmental disability records**
**☐ HIV/AIDS/STD test results ☐ Genetics testing/counseling records**

*This Authorization will expire five (5) years from the date it is signed unless revoked earlier.*

**I am aware that I have the right to know the information communicated pursuant to this Authorization. In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I am aware that I may revoke this Authorization at any time in a writing addressed to the Privacy Officer of the Practice; however, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) as authorized by law. I understand that the Practice cannot prohibit the person/entity with whom I've authorized it to receive records from disclosing information to any other person or entity, and disclosures made by such person/entity may not be protected by privacy laws. I have read and understood the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. By my signature, I knowingly and voluntarily authorize the communications/disclosures as described above.**

_____ _____
Signature of Patient Date Signed

Name of person signing on behalf of patient (if applicable) and basis for legal authority:

_____