



AUTHORIZATION TO RELEASE AND/OR INSPECT HEALTHCARE INFORMATION

PATIENT NAME _____ DOB _____
ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

I hereby authorize: _____ To disclose my protected health information, as described below to: _____
NAME/FACILITY _____ NAME/FACILITY _____
STREET ADDRESS _____ STREET ADDRESS _____
CITY/STATE/ZIP CODE _____ CITY/STATE/ZIP CODE _____

INFORMATION TO BE RELEASED:

- OFFICE NOTES DISCHARGE SUMMARY PATHOLOGY IMAGING LAB
HISTORY & PHYSICAL CONSULTATION OPERATIVE REPORT

REASON FOR DISCLOSURE:

- CHANGING PHYSICIANS PERSONAL LEGAL WORKERS COMPENSATION DISABILITY
CONSULTATION/CONTINUING CARE PAYMENT OF INSURANCE CLAIM APPLICATION FOR INSURANCE OTHER

- A listing of the statutory exception to release HIV test results without consent is available.

I understand that the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information might be re-disclosed without my authorization.

I understand that I have the right to:

- Receive a copy of this authorization
Refuse to sign this authorization and that treatment, payment, enrollment in a health plan or eligibility for health care benefits may not be contingent on my signing this authorization.
Revoke this authorization, in writing, except to the extent that the person(s) and/or organization(s) listed above have already made in reference to this authorization.

This authorization will remain in effect for 6 (six) months or until otherwise specified and will be effective for medical records generated up to the date of this signature.

Signature of patient _____ Print Name _____ Date _____

(If signed by person other than patient, stated relationship to patient)

Patient is: Minor Incompetent Deceased Legal Authority: Parent or Legal Guardian Next of Kin of Deceased