Authorization for Release of Protected Health Information

Please complete all sections of this authorization form to facilitate the release of your protected health information.

1. Patient Information

Patient Full Name:

Date of Birth (MM/DD/YYYY):

Phone Number:

Street Address:

City, State, Zip Code:

2. Authorizing Entity (Who is releasing the information?)

Name of Hospital, Clinic, or Provider:

Address/Location:

3. Receiving Entity (Who should receive the information?)

Name of Recipient (Person, Clinic, or Organization):

Recipient Phone Number:

Recipient Address:

4. Information to Be Released

Dates of Treatment to Include (e.g., "All" or specific range):

Specific Records to Release (e.g., Progress Notes, Lab Reports, Imaging):

Include sensitive information? Write YES or NO for each:

Drug/Alcohol Treatment Records:

Mental Health Records:

HIV/AIDS Test Results:

5. Purpose of Disclosure

Purpose (e.g., Personal Use, Continuation of Care, Legal, Insurance):

6. Expiration and Revocation

This authorization will expire on (Date or Event):

I understand that I have the right to revoke this authorization at any time by submitting a written request to the releasing entity.

7. Acknowledgement and Signature

By signing below, I acknowledge that I authorize the release of my protected health information as described above.

Signature of Patient or Legal Representative: _____

Printed Name of Patient/Representative:

Relationship to Patient (if Representative):

Date Signed (MM/DD/YYYY):