

## AUTHORIZATION TO USE AND/OR DISCLOSE MEDICAL RECORDS

I give authorization to the provider listed below to disclose a copy of the specific health/medical information below:

|                 |  |     |  |
|-----------------|--|-----|--|
| NAME OF PATIENT |  |     |  |
| DATE OF BIRTH   |  | SS# |  |

| TO: (Name, Address, Phone of Recipient of Records) |      |  |       |             |     |  |
|--|------|--|-------|-------------|-----|--|
| Name   |      |  |       | Phone & Fax |     |  |
| Address  |      |  |       |             |     |  |
| City/State Zip                                     | City |  | State |             | Zip |  |

| RECORDS FROM: (Who is Releasing the Records) |      |  |       |       |     |  |
|--|------|--|-------|-------|-----|--|
| Name   |      |  |       | Phone |     |  |
| Address                                      |      |  |       |       |     |  |
| City/State Zip                               | City |  | State |       | Zip |  |

**For the Following Purposes:**

|   |   |  |
|---|---|--|
| <input type="checkbox"/> Continued Medical Care | <input type="checkbox"/> Personal Information | <input type="checkbox"/> Legal Follow-up |
| <input type="checkbox"/> Disability Insurance   | <input type="checkbox"/> Other:               |  |

**By Checking the Boxes Below, I Specifically Authorize the Use and/or Disclosure of the Following Health Information And/or Medical Records, If Such Information And/or Records Exist:**

|                          |   |   |   |
|--------------------------|---|---|---|
| <input type="checkbox"/> | Please send the entire Medical Record (all information) to the above named recipient. |   |   |
| <input type="checkbox"/> | Office Notes and Reports  | <input type="checkbox"/> Diagnostic Reports           | <input type="checkbox"/> Billing Statements |
| <input type="checkbox"/> | Rx History  | <input type="checkbox"/> Transcribed Hospital Reports | <input type="checkbox"/> Laboratory Reports |
| <input type="checkbox"/> | Others Listed Here:   |   |   |

**The Following Items Must Be Initialed to Be Included in the Use And/or Disclosure:**

- \_\_\_\_\_ HIV/AIDS relate information and/or records HBV, TB or Other Communicable Diseases
- \_\_\_\_\_ Mental Health Information and/or Records
- \_\_\_\_\_ Domestic Violence
- \_\_\_\_\_ Genetic Testing Information and/or records
- \_\_\_\_\_ Drug/Alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed.) Describe:  
\_\_\_\_\_
- \_\_\_\_\_ Other: \_\_\_\_\_

**I understand** that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by HIPAA and other federal and state regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

**I also understand** that the person I am authorizing to use and/or disclose the information may not receive compensation for doing so.

**I, further understand** that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment of my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization.

**Finally, I understand** that **I may revoke this authorization**, in writing, at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless Revoked Earlier, this Authorization Will Expire in Six (6) Months from the Date of Signing or until (Insert Date):

Print Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Patient or Patient's Legal Representative: \_\_\_\_\_

Print Name of Legal Representative (if applicable): \_\_\_\_\_

Relationship to patient: \_\_\_\_\_