AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Date Revoked: ________________
Initials of Privacy Official: _________

Patient Name: ____________________________________ Medical Record No.__________________________

Address: ____

Date of Birth: ____________ Healthcare Provider Name(s): ____

I authorize you to use or disclose my health information to ____________________________________ for the purpose of _______________________________________ in the manner described below.

1. **Dates of Service**: The following dates of service(s) to be used or disclosed:

_____ All dates of services
_____ For the date ranges of ________________ to ________________.
_____ For the following dates of services ____.

2. **Type of information:** The type of information to be used or disclosed for the dates indicated above is as follows (check the appropriate spaces and include other information where indicated):

_____ **Entire medical record**	_____ **Entire billing record(s)**
_____ **Mental Health Notes**	_____ **Lab**
_____ **Medication and treatment records**	_____ **Only the information indicated below:**

_____ Other:(Describe as specifically as possible). ____

Authorization Statements:

3. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the HIPAA Privacy Rule may no longer protect the information.

4. I understand that I have a right to revoke this Authorization at any time. I understand that if I revoke this Authorization, I must do so in writing and present my written revocation to the Healthcare Provider listed at the top of this Authorization. I understand that the revocation will not apply to information that has already been released in response to this Authorization.

____ ________________________
Patient Signature Date

____
Print Name

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