

AUTHORIZATION TO RELEASE AND EXCHANGE PROTECTED HEALTH INFORMATION



Patient name: _____

DOB: _____
(MM/DD/YYYY)

Release To/From: The following organizations/providers are hereby authorized to release, exchange, and share oral and written health information with each other, regarding the Patient named above:

Release To/From:
Company/Organization/Person and Relationship: _____

Company/Organization/Person and Relationship: _____

Address: _____

Address: _____
Phone: (____) ____-____ **Fax:** (____) ____-____

Phone: (____) ____-____ **Fax:** (____) ____-____

Email: _____

Email: _____

Purpose(s) or need for which the information is to be used and disclosed: (Please check as applicable)

- | | |
|--|---|
| <input type="checkbox"/> Coordination/Continuity of Care | <input type="checkbox"/> Legal Purposes |
| <input type="checkbox"/> Disability Determination | <input type="checkbox"/> Other (Specify): _____ |

Information to be released, exchanged, and shared: (Please check next to the documents to be released & exchanged)

- | | | |
|---|--|---|
| <input type="checkbox"/> Complete Medical Record | <input type="checkbox"/> Immunization Records | <input type="checkbox"/> Labs |
| <input type="checkbox"/> Physician's Orders and Encounter Notes | <input type="checkbox"/> Treatment Plan | <input type="checkbox"/> Other (Specify): _____ |
| <input type="checkbox"/> Legal Records and Information | <input type="checkbox"/> History and Physical Exam | |
| <input type="checkbox"/> Growth Charts | <input type="checkbox"/> Psychiatric/ Psychological Eval/Notes | |

Please initial the below statements:

Initial I UNDERSTAND the information requested may include evaluation, diagnosis or treatment information regarding the following conditions: mental illness, alcohol or drug abuse, and HIV/AIDS. I understand that this information may include, when applicable, information relating to sexually transmitted diseases including Human Immunodeficiency Virus (HIV Infection, Acquired Immune Deficiency Syndrome, or AIDS related Complex) and any other communicable diseases

Initial I UNDERSTAND that I may revoke this Authorization at any time by giving written notice to the Center, except to the extent that the Center has already taken action on this request. This Authorization will expire on _____ (date), or, if left blank, **TWO YEARS** from the date of my signature (whichever event comes first). I release the Center from all liability for disclosing the requested information. I UNDERSTAND that treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization

AUTHORIZATION: I understand that authorizing the disclosure of this information is voluntary. This Authorization may be used and re-used to obtain information learned and records prepared after the date this release was signed as long as this Authorization remains valid. I understand that when information is release, it carries with it the potential for unauthorized re-disclosure and it may no longer be protected by federal confidentiality rules such as HIPAA. A copy or facsimile of this Authorization may be used with the same effectiveness as the original.

Patient OR PERSON AUTHORIZED TO SIGN FOR CONSUMER

Date

Print name if not the Patient and state how authorized to sign

WITNESS SIGNATURE and Printed Name

Date

Initial I attest that I have legal guardianship of the above Patient and/or have authority to make medical decisions on their behalf.

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