



Authorization to Use and Disclose Health Information

Authorization to release the health information of:			
Patient Name:	MRN	EMPI #	
Current Address	City	State	Zip
Social Security Number - -	Phone Number ()	Date of Birth / /	
This authorization is to release health information to:			
Name			
Address	City	State	Zip
The purpose of this disclosure is: <input type="checkbox"/> Patient Request <input type="checkbox"/> Treatment <input type="checkbox"/> Payment purposes <input type="checkbox"/> Other Specify:			
Dates of service:			
Release the following information:			
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Emergency record(s)	<input type="checkbox"/> Psychiatric record(s)	
<input type="checkbox"/> History & Physical	<input type="checkbox"/> Pathology report(s)	<input type="checkbox"/> Treatment Plan(s)	
<input type="checkbox"/> Consultation(s)	<input type="checkbox"/> Radiology report(s)	<input type="checkbox"/> Alcoholic/Drug Treatment record(s)*	
<input type="checkbox"/> Operative report(s)	<input type="checkbox"/> Lab report(s)	<input type="checkbox"/> Other records as specified: _____	
<input type="checkbox"/> Progress notes	<input type="checkbox"/> Cardiology report(s)		
Term: This Authorization will remain in effect:			
<input type="checkbox"/> From the date of this Authorization until: _____			
<input type="checkbox"/> Until the following event occurs: _____			
Unless otherwise noted above this authorization will remain in effect 180 days from the date signed.			

I understand that:

- once "this facility" discloses my health information by my request, it cannot guarantee that Recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.
- I may make a request in writing at any time to _____ to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR §164.524).
- my records are protected and cannot be disclosed without my written permission. *Alcohol/drug treatment records are protected by federal rule 42 CFR, part 2.
- this Authorization will remain in effect until the Authorization expires or I provide a written notice of revocation to the Health Information Services/Medical Record Department.

To be used if facility requests this authorization:

I understand that:

- I may refuse to sign or may revoke this Authorization at any time for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of "this facility's" treatment of me, enrollment in the health plan, or eligibility for benefits.
- I make a request in writing at any time to _____ to inspect and/or obtain a copy of the protected health information maintained at this facility to be used or disclosed as provided in the Federal Privacy Rule 45 CFR §164.524).

If I have questions about disclosure of my health information, I can contact the Health Information Services/Medical Record Department.

Signature of Patient or Legal Representative	Date
If Signed by Legal Representative, Relationship to Patient	Signature of Witness (optional)

Shaded areas for Office Use Only