AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Patient Name: _____ **Date of Birth:** _____

Address: _____ _____

Street City State Zip

I authorize _____ **to release information contained in my medical record including, but not limited to: all histories, diagnoses, consultations, treatments, services, testing, summaries of physical conditions, contributing factors, complications, prognoses, prescriptions, social histories and/or protected health information which may be available to you. This includes all information about communicable diseases and/or infections which includes HIV and AIDS. This also includes psychiatric, psychological evaluation, testing and substance abuse or social work records.**

This information should be released to:

_____

_____

_____

I understand that:

1)My signature indicates that I know what protected health information is being disclosed and what results of this disclosure may be.

2)Treatment is not contingent upon my signing this release.

3)The information disclosed may be subject to redisclosure by the recipient of you information and would no longer be protected by the HIPAA Privacy Rule.

4)I may request a revocation or revision of this authorization or any part thereof, providing the protected health information has not already been released. I must do so in writing and present my written revocation to the Practice.

5)A photocopy of this release may serve as if it were an original.

6)This authorization shall remain in effect until (date)_____ or

(event) _____.

_____ _____

Signature of Patient (or Guarantor) **Date**

If you are signing as a parent, guardian, or personal representative of the patient describe the relationship below.

_____ _____

Relationship to Patient **Print Name**