

Authorization for Release of Information

Name of Patient	Date of Birth / /
 _____ is authorized to release protected health information about the above-named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.	

Entity to Receive Information. Check each person/entity that you approve of to receive information.	Description of information to be released. Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Results of lab tests/x-rays Other: _____
☐ Spouse (provide name & phone number)	☐ Financial ☐ Medical as follows: _____
☐ Parent (provide name & phone number)	☐ Financial ☐ Medical as follows: _____
☐ Other (provide name & phone number)	☐ Financial ☐ Medical as follows: _____

Patient Information I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. <i>I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. <u>This authorization shall be in effect until revoked by the patient.</u></i>
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_____/_____/_____
Signature of Patient or Personal Representative: Date:

Description of Personal Representative's Authority (attach necessary documentation)