AUTHORIZATION TO RELEASE INFORMATION

Patient Name: _____

(Last) (First)

D.O.B.: _____ Phone Number: _____

Patient Address: _____

(Street) (City)

_____

(State) (Zip Code)

"I hereby authorize this practice to make uses and disclosure of my protected health information (information about me in my medical records and/or financial records) as indicated below"

INFORMATION REQUESTED FROM:

Dr. Name: _____

Address: _____

_____

Phone: _____

Fax: _____

INFORMATION DISCLOSED TO:

Dr. Name: _____

Address: _____

_____

Phone: _____

Fax: _____

DESCRIPTION OF RECORDS TO BE DISCLOSED:

_____

I understand the following:

A: I may revoke this authorization at any time by providing written notice to the practice.

B: I may not be able to revoke this information if the practice has already taken action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance coverage.

C: The practice will not condition treatment or payment based on my signing this authorization.

D: I am signing the authorization freely.

E: No one has pressured me to sign this authorization.

F: The information disclosed in this authorization for may be subject to re-disclosure by the practice and no longer protected by federal law.

G: I acknowledge that I have had an opportunity to review this authorization and understand the intent and the use.

H: I have received a copy of this authorization.

Patient Signature: _____ Date: _____