

Authorization for the Disclosure of My Health Care Information

Patient Name: _____ Date of Birth: _____

Previous Name(s): _____ SS #: _____

Address: _____ Phone #: _____

Information to be released by:

Name: _____

Organization: _____

Address: _____

Phone #: _____

Information to be released to:

Name: _____

Organization: _____

Address: _____

Phone #: _____

My Authorization:

You may use or disclose the following health care information (**Check ONE**):

- All health care information in my medical record for the last 2 years
- All health care information in my record
- Other (e.g., X-rays, op reports, labs, billing info), specify date(s): _____

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

- HIV (AIDS virus)
- Sexually transmitted diseases
- Psychiatric disorders/mental health
- Drug and/or alcohol use

Reason for this authorization (**check ONE**):

- Transferring Care
- Other (specify): _____

I understand that unless revoked this authorization is valid for 90 days from the date of signing. I understand that I may revoke this authorization in writing at any time except to the extent disclosure has already been made in accordance with this document.

I understand that my health care information is protected by state and federal regulations that protect the confidentiality of this information and that my health care information may not be released or disclosed without my written authorization, unless otherwise provided for by law. I also understand that if I authorize a third party that is not required to comply with such regulations to receive my health care information, my information may be re-disclosed by that party and would no longer be protected.

I understand that I do not have to sign this form as a condition for receiving treatment and that I am entitled to a copy of this authorization form at the time of signing.

I understand that if I request records for personal use, to hand-carry to another health provider, or for parties not involved in my health care, there may be a charge. "Non-emergency" release of records may take up to 10 working days. Emergency requests will be given priority processing. "Emergency" status applies only to release of records directly to another health care provider for urgent patient care. There is no charge to release records to another health care provider.

MINORS - A minor patient's signature is required in order to release the following information (1) conditions relating to the minor's reproductive care including, but not limited to, contraception, pregnancy and pregnancy termination, sterilization, and sexually transmitted diseases (age 14 and older), (2) alcohol and/or drug abuse (age 13 and older), and (3) mental health conditions (age 13 and older).

Patient's Signature: _____ Date: _____

Representative / Guardian Signature: _____ Date: _____