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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

_____
(Patient Name) (Maiden Name)

_____
(Date of Birth)

I HEREBY AUTHORIZE:

_____
(Doctor/Group/Clinic Name)

_____
(Address)

_____
(City) (State) (Zip)

To release Protected Health Information in my medical records. I understand these records may include information regarding treatment of mental health, alcohol and/or drug abuse, or HIV or other communicable diseases, if present, unless otherwise noted in #3 below.

THESE RECORDS ARE TO BE SENT TO:_____

_____

1. For the purpose of :_____
2. Specific information to be disclosed:_____
3. Specific information NOT to be disclosed:_____

* By signing this Authorization, I am giving the Health Care Provider permission to disclose confidential health records. I also understand that there is potential that the recipient may re-disclose provided information and this information may no longer be protected by law.
* I may withdraw this Authorization in writing. Withdrawal of the Authorization does not affect any disclosure of protected health information made prior to the receipt of written notice. This authorization is in effect for **180 days** from the date of signature.

SIGNATURE OF PATIENT:_____ DATE_____
(or parent/guardian/authorized representative)

SIGNATURE OF WITNESS:_____ DATE_____

****IF REQUESTED INFORMATION IS MORE THAN 20 PAGES, PLEASE MAIL ****