Authorization for Release of Medical Information

Patient Name _______________________________ DOB____________

By signing below, I hereby authorize my health information (or my child's) as more specifically described as follows: ____, to be used or disclosed for the following purposes:____.

The specific person or class of persons who are authorized to use or disclose my Protected Health Information are: (ie. who has it…):

FROM: ____

____

____

The person or class of persons to whom this office may use or disclose my Protected Health Information are: (ie. where you want it sent…):

TO: ____

____

____

I understand I have the right to revoke this Authorization, except if: a) this office has taken action in reliance upon this Authorization, or b) this Authorization was given as a condition of obtaining insurance coverage and the insurance company has the right to contest a claim made under the insurance policy.

I understand that I may revoke this Authorization by written notice to the Practice Manager.

I understand that my Protected Health Information that is used or disclosed pursuant to this Authorization may be subject to re-disclosure by the person(s) you have disclosed it to, and the privacy of my Protected Health Information will no longer be protected.

I acknowledge that I have read and understand this Authorization. I authorize the use of disclosure of my (or my child's) Protected Health Information in accordance with the terms of this Authorization.

______________________________ Signature

______________________________ Relationship to the patient (if a minor)

______________________________ Date

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