AUTHORIZATION TO DISCLOSE PROCTECTED HEALTH INFORMATION

Printed Name of Patient ______________________ Previous Names, if applicable ______________________

Date of Birth ______________________ Day Telephone Number ______________________

SEND INFORMATION TO: (Please be specific)

Provider Name/Organization:______________________

Address:______________________

City: ______________________ State: ____________ Zip: ______________

Phone#: ______________________ Fax#:______________________

INFORMATION TO BE RELEASED FROM: (Please be specific)

Provider Name/Organization:______________________

Address:______________________

City: ______________________ State: ____________ Zip: ______________

Phone#: ______________________ Fax#:______________________

PURPOSE OF DISCLOSURE: ☐Transfer of Care ☐Self ☐Specialist ☐Other (Must Complete)

INFORMATION TO BE DISCLOSED:

☐ Medical Records from last two years

☐ Summary Health Information

☐Complete Designated Record Set Dates of Service: ________________

☐Other______________________ Expiration Date (or event) ________________

If the patient is unable to sign, please indicate such and the authority to act of the person who is signing for the patient. This form must be dated with 90 days of receipt, and may be revoked at any time, providing the information has not already been disclosed. Please see our Notice of Privacy Practices for instructions as to how to revoke this authorization. We will not condition treatment on the completion of the authorization. Also, please be aware that once we disclose this information per your instructions the information is subject to re-disclosure and may no longer be protected by HIPPA of 1996. I acknowledge that I have received a copy of the Notice of Privacy practices. ______________ (Initials)

Date ________ **Signature of Patient or Representative** ______________________ **Relationship to Patient** ______________

My signature below specifically authorizes the release of Healthcare information relating to the testing, diagnosis, or treatment for:

☐ HIV/AIDS Virus ☐ Mental Health/Psychiatric Disorders

☐ Sexually Transmitted Diseases ☐ Drug, Alcohol Abuse/Treatment

Date ________ **Signature of Patient or Representative** ______________________ **Relationship to Patient** ______________