

AUTHORIZATION TO DISCLOSE PROTECTED 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

Other _____

Dates of Service: _____

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