

### AUTHORIZATION FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION


<b>Patient Identification:</b>	Name: Address: City/State/Zip: Maiden/Previous Names/Nicknames: Patient Social Security #:	Date of Birth: Phone #:	MR#:
<b>Provider</b> Who is releasing the information?	Provider/Facility Name: Address: City/State/Zip: Phone #:	Fax #:	
<b>Disclose Information to</b> Where is the information to be sent?	Provider/Facility Name/Other: Address: City/State/Zip: Phone #:	Fax #:	
<b>Information to be Released</b>	Clinic Progress Notes Hospital Progress Notes Immunization Records History & Physical Operative Report Psychiatric Evaluation Outpatient Information Laboratory Data EKG/Cardiology Reports	Radiology Reports Radiology Films ER Records Discharge Summary Pathology Report Treatment for Drug/Alcohol Consultation All Records Other (Specify): _____ _____ _____	
<b>Service Dates</b>	Time period from: _____ to _____ Concerning (Specific Diagnosis or Treatment, Auto Accident, etc.) _____		
<b>Purpose of Disclosure</b>	Continuing Medical Care Insurance Claim Consult/Second Opinion Other (Specify): _____	Personal Legal Out of Town Move	
<b>Expiration Date</b>	This Authorization will expire one year from the date of signature or on:		
<b>Revocation</b>	I understand that I may revoke this authorization at any time by sending a written notice to the health care facility/provider noted above. I understand that any release made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to privacy.		
<b>Authorization</b>	I understand that the specific information to be released will only include the items have checked above. If All Records was checked, then all categories listed will be provided. I authorize release of this specific data. I understand that if the organization authorized to receive the information is not a health plan or a health care provider the released information may no longer be protected by Federal Privacy Regulations. I have read and understand this consent. I have signed this consent voluntarily and of my own free will.		


Patient Signature/Representative: \_\_\_\_\_

Relationship to patient if not self: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_

 507.836.8611

 507.836.6700

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