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AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Please read this form carefully. The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that all the following elements must be completed for authorization to be valid.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Previous Name: \_\_\_\_\_ S. S. Number (optional): \_\_\_\_\_

I hereby request and authorize:

Person/Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

To release the protected healthcare information on the patient named above to:

(Circle Your Physician)

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This request and authorization apply to: (check all that apply)

- Checkboxes for: All Healthcare Information, Pathology and/or Lab Reports, Other, Most Recent Progress Notes, Date Range

Purpose of Request: Referral Transferring Care due to: Other

- I understand I may revoke this Authorization at any time...
I understand that my express consent is required to release any healthcare information...
I have a right to inspect a copy of the health information to be released...
My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Re-disclosure: Notice is hereby given to the patient or legal representative signing this Authorization that the company completing this request cannot guarantee that the recipient receiving the requested health information will not re-disclose any or all of it to others.

Signature of Patient/Guardian/Representative: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_