RELEASE OF INFORMATION

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1. AUTHORIZATION
I authorize _____ (healthcare provider) to use and disclose the protected health information described below to _____ (individual seeking the information).

2. EFFECTIVE PERIOID
This authorization for release of information covers the period of healthcare from:

a. ☐ _____ to _____ **OR** b. ☐ all past, present, and future periods.

3. EXTENT OF AUTHORIZATION

a. ☐ I authorize the release of my complete health record in both written and oral form (including records and information relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse). **OR**

b. ☐ I authorize the release of my complete health record in both written and oral form with the exception of the following: _____.

4. This medical information may be used by the person I authorize above for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____
Patient's Printed Name

_____ _____
Patient's Signature Today's Date