

Authorization for Release of Information (From HTPN)



I hereby authorize _____ to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider; the released information may no longer be protected by federal and state privacy regulations.

_____ Patient Name (please print)	_____ Date of Birth	_____ Social Security Number	
_____ Patient Address (City, State and Zip)		_____ Phone Number	
_____ Specific Date(s) of Service (if known)		_____ All Dates of Service	
Information to be released: (Check all that apply)			
<input type="checkbox"/> Complete Medical Records	<input type="checkbox"/> Radiology Reports & Films	<input type="checkbox"/> Registration Records	<input type="checkbox"/> Billing Records
<input type="checkbox"/> Visits & Encounters	<input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> Emergency Room
<input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> Operative Records	<input type="checkbox"/> Other: _____	

Description of the purpose of the use and/or disclosure:

The health information described herein shall be **released to:**

Category: Hospital Physician Insurance Company Attorney Patient Other _____

Name of Person or Entity (please print)

Address (City, State, and Zip)

Phone Number

Fax Number

Delivery Method: Mailing Address Fax Pick-Up Records Other _____

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until _____ (Expiration date/event).

I further understand that I may revoke this authorization at any time by notifying this practice in writing. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

_____ Signature of Patient, Parent, or Legal Guardian	_____ Date
_____ Printed Name of Patient, Parent, or Legal Guardian	
_____ Relationship to Patient	or _____ Legal Authority (Attach Supporting Documentation)