Consent for Release of Health Information

Person(s)/Organization(s) authorized to disclose/release information:

Name:___________________________________

Address:_________________________________

City/State/ZIP:___________________________

Telephone: ______________________________

Person(s)/Organization(s) to whom information may be disclosed:

Name:___________________________________

Address:_________________________________

City/State/ZIP:___________________________

Telephone: ______________________________

Specific information to be used/disclosed (please check options that apply):

- ☐ Notes, test results, form(s), other medical records, or any other verbal or written information related to health.
- ☐ Other____

This information does not include psychotherapy notes. It includes all information within the records listed above related to mental health, substance abuse, HIV/sexually-transmitted diseases, and genetic testing (including, but not limited to, information relating to treatment, prevention, history, or assessment of these issues), unless specifically noted here:___________________________

(Excluding specific types of information may prevent certain records from being released. This permission may be revoked at any time except to the extent a person/organization authorized to make the disclosure has already relied on it.)

Purpose(s) of the disclosure:____

Date or event upon which this authorization will expire:____________________________________

(If no date is provided, the authorization will expire one year from the date this form is signed.)

This authorization may be revoked (taken back) in writing at any time. This may be done by providing a written statement to the disclosing organization or person, stating that you wish to revoke this authorization. This revocation will not apply to the extent that the covered entity (or person making the disclosure) has already taken action relying on this authorization or in certain cases where the authorization was obtained as a condition of obtaining insurance coverage. If a person/organization listed above is a covered entity under HIPAA (someone required by HIPAA to protect health information), they may not condition treatment, payment, enrollment, or eligibility of benefits on whether this authorization is signed. Once this information is disclosed to the recipient, there is the possibility that it may be re-disclosed and/or may no longer be protected by HIPAA regulations.

_____________________________________ ______________________

Patient signature Date

_____________________________________ ______________________

Patient name Birth date