RELEASE OF PROTECTED HEALTH INFORMATION
AUTHORIZATION FORM

Patient's Full Name

Address

City, State Zip Code

I hereby authorize use or disclosure of protected health information about me as described below:

1. I authorize the following organizations or individuals to use or disclose my health information:

   _____

2. I authorize the following organizations or individuals to receive my health information:

   _____
   Name

   _____
   Address

   _____
   City, State Zip Code

3. The specific information that may be disclosed is (please give dates of service if possible):

_____

_____

_____

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and may then no longer be protected by federal privacy regulations.
5. I may revoke this authorization by notifying the organization providing the information in writing of my desire to revoke it. However, I understand that any action already taken relying on this authorization cannot be reversed, and my revocation will not affect those actions.
6. My purpose/use of the information being disclosed is for _____ .
7. This authorization will expire one year from the signature date below unless a different expiration date or *expiration event* is stated, as follows: _____.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice.

_____ _____
Signature of Individual **Date of Individual's Signature**
(The person about whom the information relates)

OR, if applicable –

_____ _____ _____
Signature of Guardian or Authorized Representative | **Date of Guardian's/Authorized Representative's Signature** | **Description of Authority to Act for the Individual**

A copy of this completed, signed and dated form must be given to the Individual or other signator.

Official Use Only

I hereby verify the identity of the individual requesting protected health information and the authority of the individual to have access to the protected health information.

_____ _____ _____
Date Received | **Signature of Processing Associate** | **Location Number**