

**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**

(The person about whom the information relates)

*OR, if applicable –*

\_\_\_\_\_  
**Date of Individual's Signature**

\_\_\_\_\_  
**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**