

Authorization for Disclosure of Health Information

Patient Name: _____ Date of Birth: ____/____/____
Address: _____ City: _____ State: _____ Zip: _____
E-mail Address: _____ Phone: _____

I request that my protected health information (PHI) from [healthcare provider] be disclosed to:

Recipient name: _____
Address: _____ City: _____ State: _____ Zip: _____
E-mail Address: _____ Phone: _____
Fax (healthcare provider only): _____

I authorize the following PHI to be released from my medical record(s):

- | | |
|--|---|
| <input type="checkbox"/> Entire Record | <input type="checkbox"/> Treatment Progress |
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Test Results |
| <input type="checkbox"/> Dates of Treatment | <input type="checkbox"/> Session Start/Stop Times |
| <input type="checkbox"/> Treatment Plan or Goals | <input type="checkbox"/> Prognosis |
| <input type="checkbox"/> Other (please specify): _____ | |

Covering the period of healthcare from: _____ to _____

Purpose for disclosure of information: _____

Disclosure Format (Paper is default if not marked): _____ US Mail (paper format) _____ Fax(healthcare provider only) _____ E-mail (secure format) _____ E-mail (unsecure format, i.e., Gmail, Yahoo) _____ CD/Flash drive – secure format _____ Other (please specify) _____

By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees as authorized by state/federal law.
- I have the right to **REVOKE** this authorization at any time. Revocation must be made in writing and presented or mailed to [ADDRESS] _____
Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will **EXPIRE** on the following date/event/condition: _____

If I fail to specify an expiration date/event/condition, this authorization will expire one (1) year from the date signed.

- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure.
- I have the right to receive a copy of this signed authorization. A copy or fax of this authorization is as valid as the original.

Signature of Patient or Authorized Representative

Relationship to Patient (if applicable)

Print Name

Date