Authorization for Release of Protected Health Information

I, ___________________________, do hereby give my permission to disclose my protected health information, including copies of my medical record, as described below.

1. I authorize the following person(s) and/or organization(s) to disclose my protected health information:

   Name(s): ____

   Organization(s): ____

   Address: ____

2. I authorize the following person(s) and/or organization(s) to receive my protected health information:

   Name(s): ____

   Organization(s): ____

   Address: ____

3. I authorize the release of my Medical Records Abstract (e.g. History & Physical, Operative/Procedure Reports, Clinical/Office Notes, Discharge Summary, and Diagnostic Test results).

4. I also specifically authorize the release of the following specially protected information:

   ___ HIV test results

   ___ Alcohol and Drug Abuse Records

   ___ Details of Mental Health Diagnosis and/or treatment

   ___ Confidential Communications with a Licensed Social Worker

   ___ Details of Domestic Violence Victim's Counseling

   ___ Details of Sexual Assault Counseling

5. I authorize the release of this information for the following purpose(s):

   ____

   ____

   ____

6. I understand and agree that I may revoke this authorization in writing at any time, except to the extent that the person(s) and/or organization(s) named above have taken action in reliance on this authorization.

7. I understand that I may refuse to sign this authorization. Refusal to sign this authorization will not affect the quality of my health care, but it may impede the success of my naturalization application.

8. This authorization will expire on: ________________________________.

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information and documents to the persons or agencies listed above.

Patient's Signature: _________________________________ **Date:** ____________

Print Name: ____

Address: ____

Telephone: _______________________

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Relationship or Authority of Personal Representative (if applicable)