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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Name_____ **Date of Birth**_____

Phone #_____ **Social Security #**_____

I voluntarily authorize the medical information designated below to be

☐ Obtained from:

☐ Sent to:

_____

Phone #_____ Fax #_____

* The information to be disclosed is: ___All Medical Information & Reports
___Only information from _____to_____
___Prenatal Records
___Other:_____

EXCEPTION: Do **NOT release the following information:

___HIV or AIDS information
___Information related to drug or alcohol abuse
___Psychiatric information

* The purpose of this disclosure is _____

I have the right to revoke this authorization in writing at any time prior to the release of this information. My written revocation will not affect any action taken in reliance on this authorization before revocation was received.

I understand that my treatment, benefits or payment is not conditioned on my provision of this authorization.

I understand that information disclosed by this authorization may be subject to re-disclosure by the recipient, and no longer protected by the Health Insurance Portability and Accountability Act.

This consent is effective immediately, and expires 1 year from the date signed.

_____ _____

Patient's Signature **Date**