

Authorization to Disclose Health or Billing Information

Patient: _____ Medical Record Number: _____
 Last Name: _____ First Name: _____ MI: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____ Date of Birth: _____

Information Disclosed FROM:

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____
Fax: _____

Information Disclosed TO:

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____
Fax: _____

Information to be Disclosed:

Dates of Service to be disclosed: _____

I understand that my name, date of birth, address, age, gender, phone number, other demographic and insurance information will be included in any release of health or billing information.

- | | | |
|---|--|--|
| <input type="radio"/> Discharge Summary | <input type="radio"/> Operative Report | <input type="radio"/> Radiology Report |
| <input type="radio"/> History & Physical | <input type="radio"/> Pathology Report | <input type="radio"/> Emergency Report |
| <input type="radio"/> Progress/Office Notes | <input type="radio"/> Laboratory Report | <input type="radio"/> Nursing Notes |
| <input type="radio"/> Consultation | <input type="radio"/> Complete physical form | <input type="radio"/> Entire Record |
| <input type="radio"/> Other(Specify): _____ | | |

Notice: This authorization is full disclosure of all records, including clinical findings, diagnosis treatment, assessment, recommendations for further care, names of health care personnel, dates of hospitalization and ambulatory visits, charges. It also includes any information that may be related to drug, alcohol, psychiatric conditions, and/or sexually transmitted disease, including HIV/AIDS information. These records will be disclosed unless you specifically ask us not to disclose it in the "Exclusions" section below.

Exclusion: _____

Method of Disclosure:

- In-person
 Paper copies picked up
 Paper copies faxed
 Paper copies mailed
 Other _____

Why is this information being disclosed?:

- | | | |
|---|--|---|
| <input type="radio"/> Continuing Treatment | <input type="radio"/> Insurance | <input type="radio"/> Worker's Compensation |
| <input type="radio"/> Legal Investigation | <input type="radio"/> Disability Determination | <input type="radio"/> At the Request of Patient |
| <input type="radio"/> Other(Specify): _____ | | |

Important Information for Patient/Patient Representative:

1. I understand that the person or organization that gets the information may not be a healthcare provider or health plan covered by federal privacy rules. This person or organization may also disclose the information that I have asked to be released. If this occurs I may no longer have any privacy protection.
2. I understand that I may refuse to sign this authorization. My refusal to sign will not change my ability to get treatment, payment for treatment, eligibility for benefits. I may inspect or copy any information that has been earlier used or disclosed under this authorization.
3. I understand that I have the right to change my mind. I may revoke this authorization at any time by submitting a written request to the director of HIS at the facility where I am sending this Authorization.

I HAVE READ AND UNDERSTAND THIS INFORMATION. UPON REQUEST I MAY RECEIVE A COPY OF THIS FORM AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT.

NOTICE: I understand I may be charged a fee for these copies, which will cover technician's time, supplies, used and methods of shipping.

Signature of Patient/Patient Representative: _____ Date: _____

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER THE DATE OF SIGNATURE.

Legal Authority is: Guardian Parent of Minor Attorney in Fact
 Next of Kin Executor of Estate Other: _____
 Patient is: Minor Incompetent/incapacitated Disabled Deceased
 Health Information released by: Name: _____ Title: _____ Date: _____

NOTE: This form is not to be used for research of marketing purposes or to use or disclose psychotherapy notes.