

# AUTHORIZATION TO RELEASE INFORMATION

**Patient Name:**

**Patient Address:**

**Medical Record #**

**Date of Birth** \_\_\_/\_\_\_/\_\_\_

**Other Identifier (Social Security Number):**

**“I hereby authorize this practice to make uses and disclosure of my protected health information (Information about me in my medical records and/or financial records) as indicated below”**

**THIS INFORMATION TO BE DISCLOSED TO:**

**Name of Entity:** \_\_\_\_\_

**Attention of:** \_\_\_\_\_

**Street Address of Entity:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**DESCRIPTION OF INFORMATION TO BE DISCLOSED:**

**REASON FOR REQUESTED USE OR DISCLOSURE:**

**I understand the following:**

- a. I may revoke this authorization at any time by providing written notice to the practice
- b. I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization or if the authorization was obtained as condition of obtaining insurance coverage
- c. The practice will not condition treatment or repayment based on my signing this authorization
- d. I am signing this authorization freely
- e. No one has pressured me to sign this authorization
- f. The information disclosed in this authorization may be subject to redisclosure by the practice by the practice and no longer protected by federal law
- g. I acknowledge that I have had an opportunity to review this authorization and understand the intent and the use
- h. I have received a copy of this authorization

**Patient Signature:**

**Date:**

**Signature of Patient’s Representative:**

**Relationship:**

**Date:**

**Event or Date Upon Which Authorization Will Expire:**