AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

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[A separate authorization, as defined by HIPAA, must be used if the authorization is for psychotherapy notes.]

1. _____ _____
Name of patient Birth Date

_____ _____
Street Address City, State, Zip

( ) _____
Phone Number

2. AUTHORIZES:

_____
Name of Health care Provider/Plan/Other

_____
Street Address

_____
City, State, Zip Code

3. RELEASE PROTECTED HEALTH INFORMATION TO:

_____
Name of Health care Provider/Plan/Attorney/Other

_____
Street Address

_____
City, State, Zip Code

4. INFORMATION TO BE RELEASED:

_____ Medical History, Examination, Reports
_____ Treatment or Tests
_____ Immunizations
_____ X-ray Reports
_____ Laboratory Reports
_____ Entire Medical Record
_____ Surgical Reports
_____ Hospital Records Including Reports
_____ Allergy Records
_____ Prescriptions
_____ Consultations
_____ Billing and Payment Information
_____ Other (Specify): _____

In compliance with HIPAA requirements, which require special permission to release otherwise privileged information, please release records pertaining to:

_____ Mental Health
_____ Alcoholism
_____ HIV (AIDS)
_____ Genetic Testing
_____ Cancer
_____ Other (Specify): _____
_____ Child Abuse
_____ Drug Abuse
_____ Sexually Transmitted Diseases
_____ Artificial Insemination
_____ Communicable Disease

FOR THE FOLLOWING DATE(S): _____

5. PURPOSE FOR NEED OF DISCLOSURE: (check applicable categories)

_____ Further Medical Care
_____ Insurance Eligibility/Benefits
_____ Legal Investigation or Action
_____ Personal – At the request of the individual
_____ Changing Physicians
_____ Other (Specify): _____

6. I understand that if the person(s) an/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health

information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

7. **Your Rights with Respect This Authorization**

- **Right to Receive Copy of This Authorization** - I understand that if I agree to sign this authorization which I am not required to do, I must be provided with a signed copy of the form.

- **Right to Refuse to Sign This Authorization** - I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who 1 am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. *As a provider or Health Plan, the rule permits you to condition treatment payment, enrollment in a health plan or eligibility for health* care *benefits on the* signing *of this authorization in the following circumstances:*
  (a) a health care provider may condition the provision of research-related treatment on the provision of an authorization to use and/or disclose an individual's health information for such *research;*
  (b) a health plan may condition enrollment in the health plan or eligibility for benefits on the provision of a n authorization required prior to enrollment in a health plait if (i) the authorization is for the health plan's eligibility or enrollment determinations or for *its underwriting or risk rating determination and*
  (ii) the authorization is not firs the use and/or disclosure of psychotherapy notes;
  (c) an entity subject to the Rule may condition the provision of health care that is solely for the purpose of creating health information for disclosure to a third party on the provision of an *authorization for the disclosure of the health information to such third party.*

[If you wish to make such conditions, you must include a description of these circumstances upon signing of this authorization.]

- **Right to Withdraw This Authorization** - I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the provider's medical records department. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

8. **Disclosure of Direct or Indirect Payment received by any Person or Organization Authorized to Use or Disclose my Health information** – I understand that the following person(s) and/or organization(s):_____
(If no direct or indirect payment will be received, "no one" may be inserted in the blank above.)

_____Will not be teeming any direct or indirect payment in connection with the use or disclosure of my health information.

_____Will be receiving payment, as described below, in connection with the use or disclosure of my information (describe amount or nature of any direct or indirect payment):_____
_____

9. **Expiration Date**: This authorization is good until the following date(s) _____ or event(s) (specify an event) _____
(An expiration date is not required if the authorization is for research purposes, indicate at the end of research)

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

10. **Signature of Patient:** _____ **Date:**_____