Authorization for Disclosure of Health Information

______________________	______________________
Name of Patient	Birth Date
______________________	______________________
Street Address	City, State, Zip Code
I hereby authorize:	**To disclose my protected health information to:**
______________________	______________________
Name	Name of Individual or Entity
______________________	______________________
Street Address	Street Address
______________________	______________________
City, State, Zip Code	City, State, Zip Code

Information to be released:

__Medical History, Examination Reports	__Surgical Reports	__Treatment or Tests
__Prescriptions	__X-Ray Reports	__Consultations
__Laboratory Reports	__Drug Abuse	__HIV Test Results*
__Mental Health	__Sexually Transmitted Disease	__Alcoholism

__Other (Please specify) _________________
*A listing of statutory exceptions to release of HIV test results without consent is available.

Purpose for need of disclosure

__At the request of the individual

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I understand that the health information disclosed as a result of this authorization may no longer be protected by the Federal privacy standards and my health information might be re-disclosed without obtaining my authorization.

I understand that I have the right to:

- **Receive a copy of this authorization**
- **Refuse to sign this authorization** and treatment, payment, enrollment in a health plan or eligibility for health care benefits may not be contingent on my signing this authorization.
- **Revoke this authorization**, except to the extent that the person(s) and or organization(s) listed above have already made in reference to this authorization.

This authorization will remain in effect until the following date(s):___________________________________

____ ______________________
Signature of Patient (or Legal Representative) Date

If signed by Legal Representative:

____ ______________________
Relationship to Patient (authority to act on patient's behalf) Date