

1) _____
 Name Address City State Zip
 _____ (_____) _____
 Date of Birth Daytime Phone Previous Name

2) **AUTHORIZES:**

 Name of Health Care Provider / Plan / Other

 Address

3) **TO DISCLOSE TO:**

Self [I hereby authorize _____ to pick up my records.] (Photo ID required.)

 Name of Health Care Provider / Plan / Other

 Address

4) **DATE(S) OF INFORMATION TO BE DISCLOSED:** From _____ to _____ If left blank, only
 information from the past two (2) years will be disclosed. (month/year) (month/year)

5) **INFORMATION TO BE DISCLOSED:**

All medical records related to (specify condition, treatment, etc.): _____

All billing records related to (specify condition, treatment, etc.): _____

Radiology films/images (specify test): _____

Specific records/information as follows: _____

I DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED (as defined by applicable state and federal laws):

Alcohol/Drug Abuse HIV Test Results Mental Health / Developmental Disabilities

6) **EXPIRATION:** This Authorization is good until the following date / event: _____
 Note: If this item is left blank, the authorization will expire in one (1) year from the date signed.

7) **PURPOSE** (check all that apply): Further Medical Care Legal Investigation / Action
 Insurance Eligibility / Benefits Personal (at my request) Other: _____

8) **YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:** I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. I understand that I may be charged a fee for record copies. In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I also am aware that I may revoke this Authorization by notifying the disclosing medical records/health information department in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I realize that the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law.

9) **SIGNATURE OF PATIENT / LEGAL REP:** _____ **DATE:** _____

If signed by a person other than the patient, complete the following:

1. Individual is: a minor legally incompetent or incapacitated deceased

2. Legal authority: parent* legal guardian next of kin / executor of deceased activated POA for Health Care

* By signing above, I hereby declare that I have not been denied physical placement of this child.

For Office Use Only:

