

**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, as described below, 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
- \_\_\_\_\_ Treatment or Tests
- \_\_\_\_\_ X-ray Reports/Films
- \_\_\_\_\_ Laboratory Reports
- \_\_\_\_\_ HIV Test Results\*
- \_\_\_\_\_ Mental Health
- \_\_\_\_\_ Sexually Transmitted Disease
- \_\_\_\_\_ Alcoholism
- \_\_\_\_\_

- \_\_\_\_\_ Surgical Reports
- \_\_\_\_\_ Hospital Records including Reports
- \_\_\_\_\_ Developmental Disabilities
- \_\_\_\_\_ Prescriptions
- \_\_\_\_\_ Consultations
- \_\_\_\_\_ Allergy Records
- \_\_\_\_\_ Drug Abuse
- \_\_\_\_\_ Other (Please specify) \_\_\_\_\_

\*A listing of the statutory exceptions to release of HIV test results without consent is available.

**Purpose for Need of Disclosure**

\_\_\_\_\_ At the rest of the individual

\_\_\_\_\_  
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 redisclosed without obtaining my authorization.

**I understand that I have the right to:**

- **Receive Copy of This Authorization.**
- **Refuse to Sign This Authorization** and that 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:

\_\_\_\_\_

\_\_\_\_\_

***AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION***

**Relationship to Patient (authority to act on patient's behalf)**

**Date**