

This authorization must be written, dated, and signed by patient or by a person authorized by law to give authorization.

I hereby authorize _____ the use or disclosure of my individually identifiable health information including, but not limited to, reports of my medical history and diagnosis for which I was treated or for which I am being referred for treatment, including:

_____ HIV/AIDS/STD related records _____ Mental Health Information
_____ Drug/Alcohol abuse/ dependency diagnosis, treatment or referral information

I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the release information may no longer be protected by federal privacy regulation.

Release a copy of the medical information for _____ (name of patient)
To (name and complete address of recipient) _____

The information will be used on my behalf for the following purpose(s): _____

Specific description of information to be copied:

- History & Physical Admission Summary Discharge Summary Emergency Records
 Laboratory Data Physician Progress Notes Radiology Data Diagnostic Data
 Physician Order Medication Records Nursing Notes/Record EKG Report
 Respiratory Therapy Records Consultation Pathology Report
 Copy of Complete Health Record Other: _____

Dates of Records: _____

The patient or the patient's representative **must** reads and initial the following statements:

1. This authorization expires in 90 (ninety) days from the date signed **or** _____ (specified expiration date) _____ (initials)
2. I understand that I may revoke this authorization at any time by notifying the providing organization **in writing**, but if I do, it won't have any effect on any actions they took before they received the revocation. _____ (initials)

Optional Information:

1. This authorization is limited to records regarding the following illness, diagnosis, or treatment: _____ (initials)
2. This authorization is limited to records from the following time period: _____ (initials)
3. This authorization is limited to a worker's compensation claim for injuries of: _____ (date) _____ (initials)

Signature of Patient or Patient's Representative:

(FORM MUST BE COMPLETE BEFORE SIGNING) _____ (date)

Patient's Date of Birth: _____

Patient's Address: _____

Printed Name of Patient Representative: _____

Relationship to Patient: _____

Witness: _____