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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, then the released information may no longer be protected by federal privacy regulations.

Patient name:_____

A staff member of our office must fully answer any questions you may have regarding this form. DO NOT SIGN A BLANK FORM.

Persons/organizations providing the information:_____

Persons/organizations receiving the information:_____

Specific description of information (includes dates):_____

What is the purpose of the use or disclosure?_____

I understand that my healthcare and the payment for my healthcare will not be affected by my signing this form.

I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it.

I understand that this authorization will expire on ___/___/___(DD/MM/YR)

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 affect on any actions they took before they received the revocation.

Signature of patient or patient's representative:_____

Printed name of patient's representative:_____

Relationship to the patient:_____**Date:**_____

You may refuse to sign this authorization