AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION
IN ORDER FOR THIS AUTHORIZATION TO BE VALID ALL BLANKS MUST BE COMPLETED

I, (Patient Name)_____SSN:_____

and DOB:_____, hereby authorize and consent to allow:

_____
Name of Entity Releasing Information

Address_____City/State/Zip_____
to disclose information contained in, provide access to, or provide such photocopies as may be requested of my Protected Health/Billing Information to:

_____
Name of Entity Receiving Information

Address_____City/State/Zip_____

The purpose or need for this release of information is:_____

The specific information to be used or disclosed is:

_____**ENTIRE CHART**
_____Treatment or examination rendered during the period from _____to_____

_____Face Sheet	_____Laboratories Reports	_____Progress Notes	_____Heart Cath
_____History & Physical	_____X-ray Reports	_____Physicians' Orders	_____Detail Billing
_____Discharge Summary	_____X-ray Films	_____Nurses' Notes	_____ER Records
_____Consultations	_____Pathology	_____Operative Report	

_____Other Please Specify:_____

I hereby release **Entity releasing information** and its staff from all legal responsibility or liability, which may arise from the release or reproduction of such Protected Health/Billing Information to the recipient. I understand my protected health information that is used or disclosed by this authorization may be subject to redisclosure by the recipient, and the law will no longer protect the privacy of my Protected Health Information. I understand that entity releasing information is entitled to request and receive reasonable fees for providing such photocopies of my medical record(s) as may be requested as a condition precedent to their release.

I understand that this consent is subject to written revocation by me at any time except in the circumstances in which **Entity releasing information** or its staff has taken action in reliance on it. A revocation should be sent to the **office releasing the information** as stated above. Without such written express revocation, this consent will expire on the following date:_____
If a date is not specified, this consent will expire 1 (one) year from the date of signature.

The patient must sign authorization. If the patient is a minor or is an incompetent adult, their guardian must sign authorization. If there is no guardian appointed by the Court, the authorization must be signed by the nearest relative. If the patient is unable to sign this authorization, please state the reason:_____

THIS CONSENT AND AUTHORIZATION MAY INCLUDE, BUT IS NOT LIMITED TO THE RELEASE OF PSYCHOLOGICAL, PSYCHIATRIC, ALCOHOL, DRUG ABUSE, AND HIV/AIDS INFORMATION.

_____ _____
Signature of Patient or Representative Date Signed

_____
Relationship (If other than Patient)

_____
Address

_____
City, State, Zip

_____ _____
Witness Signature Date Signed