Authorization for Release of Information (From HTPN)



and Acquired Immune Deficiency Staboratory test results, medical hi	yndrome ("AIDS"), mental illness istory, treatment, or any other this authorization. I further und	nmunicable diseases such as la s (except for psychotherapy na such related information.	idually identifiable health information Human Immunodeficiency Virus ("HIV") lotes), chemical or alcohol dependency, I understand that this authorization is and the payment of my health care will
I understand that if the recipient a care provider; the released informa			e.g. insurance company or non-health regulations.
Patient Name (please print)		Date of Birth	Social Security Number
Patient Address (City, State and Zip)			Phone Number
Specific Date(s) of Service (if known)			All Dates of Service
Information to be released: (Check	all that apply)		
Complete Medical Records	Radiology Reports & Films	Registration Records	Billing Records
Visits & Encounters	Laboratory Reports	Consultation Reports	Emergency Room
Laboratory Reports	Operative Records	Other:	
The health information described h	· · · · · · · · · · · · · · · · · · ·	Attorney Patient	Other
Name of Person or Entity (please pr	rint)		Phone Number
Address (City, State, and Zip)			Fax Number
Delivery Method: Mailing Ad	ddress Fax Pick-U	Jp Records Other_	
this authorization to be in effect un I further understand that I may re-	voke this authorization at any ti and dated with a date that is late	tion date/event). The by notifying this practice	tion unless I otherwise specify. I desire in writing. I also understand that the orization. The revocation will not affect
Signature of Patient, Parent, or Legal Guardian		Date	
Printed Name of Patient, Pare	nt, or Legal Guardian	or Legal Authorit	(Attach Supporting Documentation)

Version: 04-16-13 External Other