AUTHORIZATION TO RELEASE OR OBTAIN HEALTH INFORMATION

Name	DOB:	Request Date
Mailing Address		Telephone Number
City / State / Zip Code		Social Security #

I AUTHORIZE:

Name: ______

Mailing Address: ______

City, State, Zip Code: ______

Relationship: ______ Telephone Number: ______

☐ To Release Information TO ☐ To Obtain Information FROM

Name: ______

Mailing Address: ______

City, State, Zip Code: ______

Relationship: ______ Telephone Number: ______

The purpose of the authorization is: (Select the box(es) that apply.)

☐ Further Medical Care ☐ Personal ☐ Legal Investigation or Action ☐ Changing Medical Providers
☐ Participation in Research Study ☐ Marketing ☐ Creating Health Information for Disclosure to a Third Party
☐ Other: (Specify) ______

I authorize the release of the following health information: (Place an "X" in the box(es) that apply to the information you want released or you want to obtain. Authorization for release of psychotherapy notes may not be combined with authorization for release of other medical records – use separate forms if needed.)

☐ Entire Record ☐ Medical History, Examination, Reports ☐ Treatment Plan ☐ Prescriptions
☐ Immunizations ☐ Hospital Discharge Summary ☐ Laboratory Results ☐ Imaging Reports
☐ Psychotherapy Notes
☐ Records from (date) ______ to (date) ______
☐ Records related to the following specific condition(s), test(s) or treatments(s): ______

______

☐ Other: ______

This authorization shall expire (date or event):______. I understand that if I do not specify an expiration date, this authorization will expire six months from the date on which it was signed.

I understand that I may revoke this authorization at any time in writing.

I have read and understand the *Important Information about Authorization* contained on the back of this page.

______ ______
Signature of Individual or Personal Representative Authorized by Law   Date

If signed by Personal Representative, basis of authority: ______