AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name		Date	of Birth	
The above named person When information is In six months On date		☐ In o	tion is to expire: ne year nree years	
The person named above Name of Person, Provider, or Facility Address Phone Fax	ve is or has been a pa	tient of		
The person named abov	·	Na	ame of Person, Provider, or F	ŕ
Request health infoDiscuss health info			Send health information Discuss health information	
The person named above representatives of Name Of Person, Provider, Or Facility Address	ve authorizes informa	tion to be I	requested or released	by
Phone Fax				
Scope				
•	ding assessment, diagr	nosis, and tr	reatment of patient's con	dition, concern,
All information regard by patient between the		Starting Da	and	Ending Date
Other information (sp	pecify):			
Authorization				
	Printed name of Patient of	or Authorized	Representative	
Signature of Patient or Authorized Representa	Date ative		Signature of witness	Date
If not signed by the patien	nt, indicate relationship	of authorizii	ng person to patient:	
	f minor child ator of conserved patie nal Representative of a		ndividual	

Certain information is covered by additional protection and requires specific authorization. To authorize release or discussion of the following type of information, the person named above must initial and date each item. If an item is not initialed and dated, the information, if such information exists, cannot be released or discussed.

Initial	Date		From	То
		Alcohol or Drug Use/Abuse Treatment		
		Mental Health Treatment		
		HIV Status or Treatment		

The above named person has the following rights:

- This authorization is effective for the above requested and authorized health care information only. You may ask for and receive a copy of this authorization form.
- This authorization will expire on the date you indicated above. Additionally, you may revoke this
 authorization at any time by submitting a written request to this clinic or caretaker. Your
 revocation will be honored except to the extent that is been acted upon in good faith while in
 force.
- You have the right to inspect the information you are authorizing to be re-released. This and other specific rights regarding the handling of your health information are outlined in our Privacy Practices document.
- The information you are authorizing to be released could be re-released or disclosed by the
 recipient. such additional disclosures or releases may not be prohibited by law. We are not
 responsible for the actions of others who may be provided with information released as a result
 of this authorization.
- You may refuse to sign this authorization. Such refusal will not affect your ability to obtain treatment except to the extent that the information being requested may assist your health care provider in determining appropriate treatment. Your refusal to sign this authorization will not affect your eligibility for benefits

PLEASE NOTE: Unless otherwise specified by law, we will release only that information which has been created by our employees or agents, including chart notes, lab results, summaries, and consultation reports. Records created by and available from other providers, hospitals, or other care facilities must be obtained directly from those other providers or facilities.

There may be a fee associated with the copying of your records. If for personal use, you are entitled to one copy of your personal health information record free of charge. Additional copies for you, future releases to you, or releases to other providers, persons or facilities may be subject to a reasonable charge. Please contact a clinic office manager or site administrator for additional information about applicable copying fees.