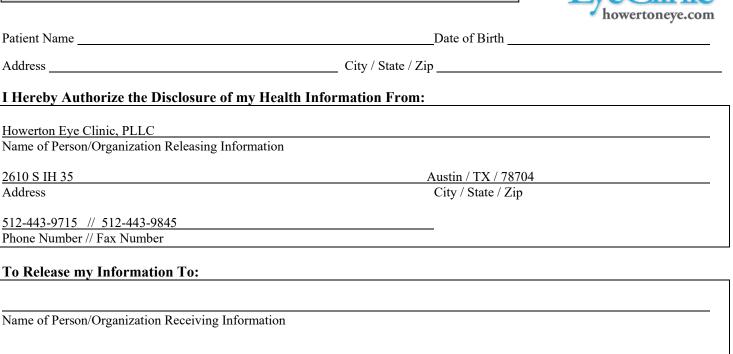
## AUTHORIZATION TO RELEASE HEALTH INFORMATION



Address

Address

City / State / Zip

Phone Number // Fax Number

## **INFORMATION TO BE RELEASED:**

Complete Medical Record

\_\_\_\_\_Medical Records for Specific Dates of Service (please list) from\_\_\_\_\_\_to \_\_\_\_\_ Other (please list)

This authorization will remain in effect until the information has been forwarded as requested and valid for a period of 1 year unless otherwise stated above or revoked through medical records.

## **RIGHTS OF THE PATIENT:**

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. Any information received by this office for our own use will continue to be protected by the Federal Privacy Rule (HIPPA). I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document by written notification. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

X	X	
Printed Name of Patient or Personal Representative	Signature of Patient or Personal Representative	DATE
Description of Personal Representative's Authority (attac	ch necessary documentation)	
*******	**********	******
Date Sent: By:	Via:	