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AUTHORIZATION FOR RELEASE OF INFORMATION

Section A. Must Be Completed For ALL Authorizations

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Name: _____

Date of Birth: _____

Organization Providing The Information **Organization Receiving The Information**

_____
_____
_____

Specific Description of The Information (including date (s) of health care) To Be Disclosed:

_____
_____

Section B. Must Be Completed ONLY If A Health Plan Or Health Care Provider Has Requested The Authorization

1. The health plan or health care provider must complete the following:
   a. What is the purpose of the use or disclosure?

      _____

   b. Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes No

2. The patient or the patient's representative must read and initial the following statements:
   a. I understand that my health care and the payment for my health care will not be affected if I do not sign this form. Initials_____
   b. I understand that I may see and copy the information described on this form if I ask for it, and that I will receive a copy of this after I sign this form. Initials_____

Section C. Must Be Completed For ALL Authorizations

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on _____/_____/_____. Initials_____
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing. Should I do so, this action will not have any effect on any actions taken by the providing organization before they received the revocation. Initials_____

Signature Of Patient Or Patient's Representative (form must be completed before signing) _____ Date _____

Printed Name Of Patient's Representative:_____

Relationship To Patient:_____

*****YOU MAY REFUSE TO SIGN THIS AUTHORIZATION*****

This form may not be used to release information for treatment or payment except when the information to be released is psychotherapy notes or certain research information.