

# Authorization to Release Health Information

Expires upon one time release

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**Patient Information:**

Name of Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

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**I authorize the practice below to release my health information:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**Please forward/release my health information to:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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The information below is provided at the request of the patient. (Describe PHI needed)

\_\_\_\_\_  
\_\_\_\_\_

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**This authorization shall be in effect until the information has been forwarded as requested.****Patient Information**

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. *I understand that information 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.*

I understand that I have the right to revoke this authorization by sending a written notification to the address below and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to \_\_\_\_\_

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\_\_\_\_\_  
Date \_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Description of Personal Representative's Authority (attach necessary documentation)

Revised Jan 2008