Consent Form to Release Health Information

Client name: _____

Section 1

Patient Information

First name _____ Middle name _____ Last name _____

Previous name(s) _____

Home address

_____

City _____State _____ Zip code_____
Daytime phone _____E-mail address (optional)_____

Section 2

I am requesting health information be released FROM at least one of the following:

Organization name _____
Address_____

Specific health care professional's name

_____

Section 3

I am requesting that health information be sent TO:

Organization name _____

And/or name: First name _____ Last name_____
Mailing address:

_____

_____

City _____ State _____Zip code_____
Phone (optional) _____ Fax (optional)_____
Information needed by (date): ___ / ___ / _____ (optional)

Section 4

Information to be released IMPORTANT: indicate only the information that you are authorizing to be released.

- ☐ Specific dates/years of treatment _____
- ☐ All health information

OR to only release specific portions of your health information, indicate the categories to be released:

☐ History/Physical	☐ Mental Health	☐ HIV/AIDS Testing
☐ Laboratory Report	☐ Discharge Summary	☐ Radiology Report
☐ Emergency Room Report	☐ Progress Notes	☐ Radiology Images
☐ Surgical Report	☐ Care Plan	☐ Photographs/video/digital/image
☐ Medications	☐ Immunizations	☐ Billing Records
☐ Chemical Dependency	☐ Psychotherapy	

- ☐ Other info or instructions _____

Section 5

Health information includes written and oral information

☐ Oral only	☐ Written only	☐ Oral and Written

Section 6

Reason(s) for releasing information

- ☐ Patient's request
- ☐ Review patient's current care
- ☐ Treatment/continued care
- ☐ Payment
- ☐ Insurance Application
- ☐ Legal
- ☐ Other _____

Section 7

I understand that by signing this form, I am requesting that the health information specified in Section 4 be sent to the third party named in section 3. I may stop this consent at any time by writing to the organization(s), facility(ies) and/or professional(s) named in section 3. If the organization, facility or professional named in section 2 has already released health information based on my consent, my request to stop will not work for that health information. I understand that when the health information specified in section 4 is sent to the third party named in section 3, the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws. I understand that if the organization named in section 3 is a health care provider they will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form. If I choose not to sign this form and the organization named in section 3 is an insurance company, my failure to sign will not impact my treatment; I may not be able to get new or different insurance; and/or I may not be able to get insurance payment for my care.

This consent will end one year from the date the form is signed unless I indicate an earlier date or event here: Date ____/____/____ Or specific event _____

Section 8

Patient's signature_____
Date___/___/_____

OR

legally authorized representative's signature _____
Date___/___/_____

Representative's relationship to patient (parent, guardian, etc.) _____