AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

Name of Patient ______________________________ Chart No. ______________

Date of Birth ______________ Phone # ______________ Social Security # ______

I authorize: ______________________________

To release to: ______________________________
____
____

SPECIFIC DESCRIPTION OF INFORMATION TO BE USED AND DISCLOSED

(specify dates for each, unless "entire medical record" is selected)

Treatment from ______________________ (date) to ______________ (date)

____ Hospital Admissions Summary
____ Hospital Discharge Summary
____ Operative Report
____ Progress Notes
Entire Medical Record for all dates
____ Billing Information
____ Lab Reports
____ X-ray Reports
____ X-ray Films
____ Psychiatric Intake
Immunizations
____ Pathology Report
____ Other (please specify)______________________________
____ I authorize verbal and/or written exchange about my medical information

I AUTHORIZE RELEASE OF ALL ALCOHOL AND/OR DRUG ABUSE RECORDS THAT ARE PART OF THE RECORDS I SPECIFIED ABOVE, UNLESS OTHERWISE INDICATED HERE:
____ Do not release records from alcohol or drug abuse treatment programs that are protected under federal law.

PURPOSE OF THE USE AND DISCLOSURE

____ Further Treatment **(Date of Appointment)**
____ Insurance Application
____ Disability Determination
____ Vocational Rehabilitation Evaluation
____ At my request
____ Other ______________________________
Personal Records
Education
____ Payment of Insurance Claims
____ Legal

I authorize the use and disclosure of my individually identifiable health information as described above. I understand that this authorization Is voluntary. I understand that if the person or organization I authorize 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 and could be re-disclosed. I understand that my health care and payment for my health care will not be affected if I do not sign this form.

I understand that I may revoke this authorization in writing at any time, except to the extent action has already been taken in reliance on it. I understand that this authorization will expire on: ______________ (specify date or event) or, if no date or event is specified, 12 months from the date of signing.

A photocopy or fax of this authorization will be treated in the same manner as the original.

____
Signature of Patient/Guardian/Representative Date

____
(If not patient, state authority/relationship)