AUTHORIZATION TO DISCLOSE INFORMATION

Patient Name: _____ Date of Birth: _____DOC#_____

1. I, _____[patient], hereby authorize _____ [institution] ("you") to furnish full and complete medical records, including records containing private health information, or a copy thereof, requested by _____ [designee]**.** For purposes of this authorization, "information" means all records or knowledge concerning my health, any injuries, medical history, mental and physical conditions, before and after the date of this authorization, regardless of the time of occurrence. For purposes of this authorization, the term "records" includes, but is not limited to, written or graphic documentation, including notes, billing records or statements, sound recordings, computer records and diagnostic documentation such as X-rays, lab test results, or other test results. This authorization also extends to the release of any records received by you from other providers.

2. You are requested to cooperate and communicate directly with _____ [designee] and furnish such information as may be requested and to assist in the collection of any and all information requested. You should not disclose information to any other person without my written authorization unless required by law to do so.

3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. This information may be disclosed to and used by _____ [designee]. I agree that: (1) This authorization overrides any existing agreement to restrict information pursuant to 45 CFR 164.502(b)(2)(ii); (2) I understand that I have a right to revoke this authorization in writing by mailing the revocation to _____ [designee] or to _____ [institution] ("you"); (3) A copy of this authorization is as valid as an original; (4) I understand that the information provided pursuant to this release might be re-disclosed as necessary for purposes of representing me and no longer protected under HIPAA; and (5) I have read and understood this authorization.

5. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. This authorization will expire **two years** from the date written below, opposite to my signature.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

_____ _____

Patient Signature Date