



**PATIENT AUTHORIZATION FOR RELEASE OF INFORMATION**

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand 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, and that it may be re-disclosed by the recipient.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Name/Address of Organization Providing the Information: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Name/Address of Organization(s) or Person(s) Receiving the Information: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Specific Description of Information Disclosed \_\_\_\_\_

To the extent any of the following information is contained in my records being released, **I specifically authorize the release of such information** for the purposes indicated below by **initialing** before each category:

- Initials: \_\_\_\_\_ HIV/AIDS testing, test results, treatment and related information including high risk behavior documented;
- Initials: \_\_\_\_\_ drug and/or alcohol diagnosis, treatment, test results and reports and referral information;
- Initials: \_\_\_\_\_ mental health treatment information, test results and reports including psychological and psychiatric studies, reports, evaluations and referral information; and/or
- Initials: \_\_\_\_\_ venereal disease information;
- Initials: \_\_\_\_\_ genetic testing, test results, counseling, reports, treatment, and referral information.

Purpose of Disclosure: \_\_\_\_\_

**You must read and initial the following statements:**

1. I understand this Authorization will expire on \_\_\_\_/\_\_\_\_/\_\_\_\_ (DD/MM/YR) or on the following event: Termination of the Physician/Patient Relationship. Initials: \_\_\_\_\_
2. I understand that I may revoke this Authorization at any time by notifying this Practice's Privacy Officer in writing, but if I do, it will not have any effect on any actions this Practice took before they received the revocation. Initials: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Representative      Relationship to Patient      Date

\_\_\_\_\_  
Witness      Date

**You may refuse to sign this Authorization. We cannot condition treatment on your signing this Authorization.**

**N/A. If this Authorization is for marketing purposes, remuneration is/is not involved (Provider circle one).**