Authorization for the Release and/or Discussion of Protected Health Information

Patient Name:_____ SS#: _____-_____-_____Birth Date: ___/____/_____

Authorization

1. I, _____, hereby authorize
(Name of Patient or Patient's Legally Authorized Representative)

2. Name of person or organization:_____

Street Address: _____

City, state, zip:_____ Telephone: ( )

3. **A.** To release and/or discuss the following information

Complete Record Outpatient Care Inpatient Care

X-Ray Results Laboratory Results Treatment Plan Update

Other

_____

If my record contains the following information, it is also released if *CHECKED* in boxes below:
☐ Substance Abuse ☐ Mental Health Treatment ☐ HIV Testing or Treatment

4. To _____of {name, address and phone of organization]

This information release is at my request for the purpose of legal assistance.

5 Signature:

I have carefully read and understand the above information, and do herein consent to its disclosure. I am aware that information regarding my medical condition will be released to those persons or agencies named above. I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

I understand that this consent is subject to revocation, in writing, at any time, unless action based on it has already begun.

This authorization expires _____6 months _____one year from today's date, or upon the following specified event:

_____.

I authorize the use of a copy of this form for the disclosure of the information described above.

Signed _____ Relationship_____ Date: ____/____/____