AUTHORIZATION FOR USE/DISCLOSURE
OF HEALTH INFORMATION

Authorization for Use/Disclosure of Information

I, ____________________________, born on ______________________, hereby voluntarily authorize

__________________________ to disclose my protected health information from _________________, 2014 to

__________________ to the following **Recipient(s)/Requesting Provider(s)**

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Information to be disclosed: I authorize the release of the following health information: (check the applicable box below)

- ☐ Any and all types of records you have for this patient
- ☐ Emergency room notes
- ☐ Urgent care notes
- ☐ History and Physical
- ☐ Discharge summary
- ☐ Psychological testing
- ☐ Hospital Progress notes
- ☐ Operation or procedure notes
- ☐ Clinical notes
- ☐ Lab reports
- ☐ Radiology reports
- ☐ Consultations

Purpose: I authorize the release of my health information for the following specific purpose:

Clinical evaluation, diagnosis and treatment

I understand that this Authorization will remain in effect

- ☐ From the date of this Authorization until the _____ day of ________, 20___.
- ☐ Until the Provider fulfills this request

and I can revoke this authorization at any time. I also understand that I am not required to sign this authorization for release of confidential information and that my health care will not be affected by my refusal. By signing this form, I understand that I am entitled to receive a copy of this authorization but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received. I acknowledge that the material authorized for release may contact information about substance abuse, psychiatric history, and HIV testing or results.

______________________________ ____________________ ________________________________
Signature of Patient Date Signature of Witness