AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

The fee for duplication and transfer of records, as allowed by state law will be $20.00 per patient. This charge is due before we release the records. _____ Initials

Patient Name _____Date of Birth _____ ID#_____

1. I authorize the use or disclosure of the above named individual's protected health information as described below:
2. The following individual(s) or organization(s) is authorized to make the disclosure:

   Provider _____

   Address _____

   Phone _____ Fax _____

3. The type of information to be used or disclosed is as follows (check and/or include description)
   _____ All Records
   _____ Records only from (date) _____ to (date) _____
   _____ Records pertaining to (describe) _____
   _____

4. I understand that the information in my health record may include information relating to pregnancy, sexually transmitted disease, AIDS, AIDS related syndromes or HIV testing. It may also include information about behavior or mental health services, alcohol, drugs, psychiatric and psychological information.

5. Release records for use by or disclosure to:
   Name/Provider _____

   Address _____

   Phone _____ Fax _____

6. Disclosed information will be used for the following purpose:
   _____ My personal records
   _____ Transfer of care due to dissatisfaction with the practice
   _____ Transfer of care due to relocation (please leave a contact address and phone # with our office)
   _____ Other (please describe) _____

7. I understand that once the above information is disclosed it may be re-disclosed by the recipient and may no longer be protected by federal or state privacy regulations.
8. I understand that I have the right to revoke this authorization at any time by presenting my written revocations to the Privacy Official. I understand that the revocation will not apply to information that has already been released in response to this authorization.
9. This authorization will expire on the following date or event _____. If I fail to specify an expiration date or event, this authorization will expire in ninety (90) days.
10. I understand that authorizing this disclosure of this health information is voluntary. I need not sign this forms to assure healthcare or treatment.

_____ / _____ / _____ / _____

Signature or patient/representative | Relationship to patient | Phone Number | Date

We proudly accept 

cash or checks.