Authorization for Release of Information

Section I: Information About the use or Disclosure
I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.

Patient name: _____ ID number:_____ Patient date of birth:_____

Patient address: _____ Patient account number: _____

Provider name & phone number: _____ Date of service: _____ Billed amount: _____

Persons/organizations authorized to provide the information: _____
_____
_____

Persons/organizations authorized to receive the information: _____
_____
_____

Specific description of information to be used or disclosed (including date(s)): _____
_____

Specific purpose of the disclosure:_____
_____

Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? No_____ Yes (describe)_____
_____

This authorization will expire _____ (indicate date, or an event relating to you personally or to the purpose of the authorization).

Section II: Important Information About Your Rights
I have read and understood the following statements about my rights:

- ❑ I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation will not have any affect on any actions the entity took before it received the revocation.
- ❑ I may see and copy the information described on this form if I ask for it.
- ❑ I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).
- ❑ The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving entity. I have the right to seek assurances from the above-named persons/organizations authorized to receive the information that they will not redisclose the information to any other party without my further authorization.

Section III: Signature of Patient or Patient's Representative

_____ _____
Signature of patient or patient's representative Date
(Form must be completed before signing)

Printed name of the patient's personal representative:_____

Relationship to the patient, including authority for status as representative:_____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

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