AUTHORIZATION FOR RELEASE OF INFORMATION

Section A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that 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.

Patient Name:____ DOB:_________________________________

Entity providing the information: ____ ____

Entity receiving the Information: ____ ____

Specific description of information (including date(s)):____

____

Section B: Must be completed only if a health plan or a health care provider has requested the authorization

1. The Health plan or health care provider must complete the following:
   a. What is the purpose of the use or disclosure?____

   b. 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?
   YES_________ NO__________

2. The patient or the patient's representative must read and initial the following statements:
   a. I understand that my health care and the payment for my health care will not be affected if I do not sign this form. Initials:_______

   b. I understand that I may see and copy the information described on this form if I ask for it and that I get a copy of the form after I sign it. Initials:_______

Section C: Must be completed for all authorizations

The patient or the patient's representative must read and initial the following statements:
1. I understand that this authorization will expire on ____/______/______ (DD/MM/YYYY) Initials:_______
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it will not have any affect on any actions they took before they received the revocation. Initials:_______

____ __________________________
Signature of patient or patient's representative Date
Form MUST be completed before signing

____ __________________________
Printed name of patient's representative Relationship to patient

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

rev 12/09