AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Information

Name of Patient: ______________________________ D.O.B.: ________________

Mailing Address: ____

City: ____________________ State: ______ Zip: __________ Phone: ____________

At my request, I ______________________________, do hereby authorize the release of:
(Patient name or Legal Guardian)

- ☐ Entire Record
- ☐ Financial Records
- ☐ Diagnostic Studies: ____________
- ☐ Op Report
- ☐ Office/Visit Notes: ____________
- ☐ MRIs / X-rays/Imaging
- ☐ Date(s) Of Service: ____________

Health Information Released FROM: *(Hospital and Clinics)*

Person/Organization: ____

Street Address: ____

City: ______________________________ State: ______ Zip: __________

Fax: ____________________ Phone: ____________________

Heatlh Information Released TO:

Person/Organization: ____

Street Address: ____

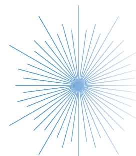
City: ______________________________ State: ______ Zip: __________

Fax: ____________________ Phone: ____________________

This authorization will terminate in one year unless otherwise specified: ____________ understand that I may stop this release at any time by writing to the HHS's HIM department. Once health information has been released to another facility or provider, there is no way to cancel or stop the release. I understand that when the health information is released the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws. I understand that HHS not condition treatment, payment, enrollment or eligibility for benefits on whether sign the consent form. I understand that I must sign this form to release my health information.

X______________________________________ _____/_______/______

Signature of Patient or Guardian or Personal Representative **Date**



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