AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

_____

Patient Name

_____

Address

_____ _____ _____

Phone Date of Birth Social Security Number

Records are requested FROM:

_____

Name

_____

Phone/Fax

_____

Address

To be disclosed TO:

_____

Name

_____

Phone/Fax

_____

Address

The type and amount of information to be disclosed is as follows:

☐ My health information relating to the following treatment or condition:
_____
☐ Most recent 3 years of record
☐ My health information for the date(s): _____
☐ Entire medical record
    ☐ Include ☐ Exclude: My health information related to drug and/or alcohol abuse
    ☐ Include ☐ Exclude: My health information related to HIV/AIDS
    ☐ Include ☐ Exclude: My health information related to psychological or psychiatric conditions
☐ Other: _____

Purpose of disclosing this health information: _____

I authorize the disclosure of health information of the individual(s) named above:

_____ _____
Signature Date

_____ _____
Patient's Personal Representative (print name) Relationship