**Patient Information: I give permission to release the health information of:**

**Patient Name:** ________________________________________ **DOB:** ________________________________________

**Street Address:** ________________________________________ **Telephone:** ___________________________________

**City, State, Zip:** ________________________________________ **Email address:** _______________________________

| **Release Information From:** | **Release Information To:** |
|---|---|
| ___________________________________________ | ___________________________________________ |
| **(Name of appropriate facility or doctors office)** | **(Name of facility, doctors office, or company)** |
| ____________________________________________ | ___________________________________________ |
| **(Address)** | **(Address)** |
| ____________________________________________ | ___________________________________________ |
| **(Phone number)** **(Fax number)** | **(Phone number)** **(Fax number)** |

**Please check all that may apply of what you want released:**

☐ Office Visits/Progress Notes ☐ Clinical Comprehensive Assessment ☐ Entire patient record

☐ Laboratory Reports ☐ Medications ☐ Other: _____________________

**Purpose of release (Please check one):** ☐ Continued patient care ☐ Insurance

☐ Legal purpose ☐ Other: _____________________

## PATIENT RIGHTS – I UNDERSTAND THAT:

I understand that I have a right to revoke this authorization at any time by notifying the Medical Record Department of the above named organization in writing. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that I may request to inspect or obtain a copy of the information to be used or disclosed. I understand that my treatment cannot be conditioned on signing this authorization unless I am being treated so that a third party can receive my health information, such as employer for a return to work evaluation or insurance company for eligibility. If the patient is a minor, a parent or guardian must sign. I understand this permission is valid 1 year after the date of my signature unless otherwise noted.

☐ I acknowledge and hereby consent that the released information may contain alcohol, drug abuse, psychiatric, HIV results or AIDS information.

☐ I authorize the release of any records regarding drug, alcohol or mental health treatment to the person listed above.

**Signature:** ______________________________________________ **Relationship to Patient:** ___________________________

**Print Name:** ______________________________________________ **Date:** ____________________