

DRAFT - AUTHORIZATION TO RELEASE HEALTH INFORMATION - DRAFT

Patient Name		Date of Birth
Social Security Number		
Address		

Provider authorized to release the Health Information (the "Provider"):	<i>(Name of releasing entity)</i>
Entity to receive the Health Information (the "Recipient"):	<i>(Name of receiving entity)</i>
Recipient's Address:	<i>Address</i>
	<i>Attention:</i>

Dates of service of the Health Information that is covered by this authorization:			
	Start date:		End date:
	Start date		End date:
Health Information related to the patient to be released under this authorization:			
	Complete health record		
	Discharge summary		Progress Notes
	History & physical examination		Laboratory tests
	Consultation reports		X-ray report
	Other (Please specify):		
The following information will be release when included in the above unless you indicate otherwise:			
	Do not release any AIDS or HIV test results		Do not release any records of psychiatric care
	Do not release any records of alcohol/substance abuse treatment		
	Other:		

Purpose of disclosure:

Authorization expiration date or event:

The undersigned patient (or personal representative on behalf of the patient) hereby authorizes the Provider named above to release the Health Information described above to the Recipient named above. The patient has the right to refuse to sign this authorization.

The Provider cannot condition treatment, payment, enrollment, or eligibility for benefits on the patient providing this signed authorization. The Patient has the right to inspect and copy his health information that is included in a designated record set, subject to the exceptions found in 45 CFR 164.524.

This authorization to release the health information listed above can be revoked at any time (upon written notification to the Recipient at the above address) except to the extent that Provider has already released the Health Information before obtaining receipt of the revocation. This authorization will expire on the expiration date or event listed above.

When the Patient's health information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the Recipient or any of its agents and/or employees and may no longer be protected by 45 CFR Parts 160 and 164.

A photocopy of this authorization may serve as an original.

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If the patient (or personal representative) signs this authorization at the request of the Provider, complete the following:			
<input type="checkbox"/>	The Provider will not receive a monetary benefit from the use of the patient's information	<input type="checkbox"/>	The Provider will not receive a monetary benefit from the use of the patient's information
<input type="checkbox"/>		<input type="checkbox"/>	Not applicable

<i>Patients signature</i>	<i>Date</i>
<i>Personal representative's signature (if necessary)</i>	<i>Date</i>

Personal Representative	
If it is necessary for a personal representative to sign and date this authorization due to lack of capacity of the patient, including minority, interdiction or any other legal reason, indicate below how the person signing as personal representative has authority to do so:	
<input type="checkbox"/>	(1) The judicially appointed tutor or curator of the patient, if one has been appointed.
<input type="checkbox"/>	(2) An agent acting pursuant to a valid mandate, specifically authorizing the agent to make health care decisions.
<input type="checkbox"/>	(3) The patient's spouse not judicially separated.
<input type="checkbox"/>	(4) An adult child of the patient.
<input type="checkbox"/>	(5) Any parent, whether adult or minor, for his minor child.
<input type="checkbox"/>	(6) The patient's sibling.
<input type="checkbox"/>	(7) The patient's other ascendants or descendants.
<input type="checkbox"/>	(8) Any person temporarily standing in loco parentis, whether formally serving or not, for the minor under his care and any guardian for his ward.
<input type="checkbox"/>	(9) Other (Please specify):