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Release of Confidential Health Information

I, _______________________, hereby authorize ________________ to release to:
(Name of Patient or Authorized Agent)

____
(Name of Healthcare Facility, Physician, Agency, etc.)

____
(Street address, City, State, and Zip Code)

The following information contained in the patient record of ________________________________
(Patient's name)

Born ________________, residing at ____
(Birth Date) (Street Address, City, State and Zip Code)

☐ The entire medical record, **excluding** mental health treatment, and HIV/ acquired immune deficiency syndrome (AIDS) records

☐ Mental Health Treatment Records ☐ HIV/ Acquired Immune Deficiency Syndrome (AIDS) Records

☐ Alcoholism Treatment Records ☐ Laboratory Reports

☐ Drug Abuse Treatment Records ☐ X-ray Reports

☐ Operative Notes ☐ Other: ____

The purpose(s) of the authorization is (are) ____
____

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law.
I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of healthcare is solely for the purpose of creating protected health information for disclosure to a third party.
I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.
I understand that this authorization is valid until it expires, unless revoked before that.
I understand that I may revoke this authorization at any time by giving a written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in revocation must be sent to the physician's office. Absent such written revocation, this Authorization for Release of Confidential

Signed: ____ Date: _________________
If you are not the patient, please specify your relationship to the patient: