

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA**

Patient Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Patient Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV\* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize the release of such information to the person(s) indicated in Item 8.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact HHS and/or the state agencies responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).

7. Name/address of health provider or entity that this release is directed to: \_\_\_\_\_

\_\_\_\_\_

8. Name/address of person(s) or category of person to whom this information will be sent: \_\_\_\_\_

\_\_\_\_\_

9. Specific information to be released (check boxes and complete, as appropriate):

Medical Record from (insert date) \_\_\_\_\_ to (insert date) \_\_\_\_\_

Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

Other: \_\_\_\_\_

Include: (*Indicate by Initialing*)

\_\_\_\_\_ Alcohol/Drug Information

\_\_\_\_\_ Mental Health Information

\_\_\_\_\_ HIV-related Information

10. Reason for release of information: \_\_\_\_\_

11. Date or event on which this authorization will expire: \_\_\_\_\_

12. If not the patient, name the person signing this form: \_\_\_\_\_

13. Authority of the person identified above to sign this form: \_\_\_\_\_

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

\_\_\_\_\_  
Signature of Patient/Representative

\_\_\_\_\_  
Date: