**Authorization for Release and/or Disclosure of Health Information**

I authorize the disclosure of my personal health information to the persons/entities as described below. I understand this authorization is voluntary and made to confirm my directions. I understand that once the information is disclosed, it may be re-disclosed and no longer protected by federal privacy regulations. I hereby give permission to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to disclose my personal health information in the manner described herein.

PARTICIPANT’S INFORMATION:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical Record #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Request Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHI MAY BE DISCLOSED BY:

Person/Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHI MAY BE DISCLOSED TO:

Person/Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PERSONAL HEALTH INFORMATION TO BE DISCLOSED:

1. Specify records to be released and /or disclosed:

 □ General Medical Information (from\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

 □ Information Regarding Specific Injury or Treatment (from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

 □ X-Ray/Laboratory Results of (from \_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

 □ Mental Health (from \_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) Initials of Participant or Representative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 □ Alcohol/Drug (from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_) Initials of Participant or Representative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ HIV Test Results (from \_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_) Initials of Participant or Representative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Your request will be deemed to include any information related to sexually transmitted disease, alcohol or drug use or treatment, or mental health/psychology/psychiatry that may be within your above request, unless you specifically state your objection here:

Right to Revoke: I understand that I may revoke this authorization in writing at any time. I understand my revocation will NOT affect any disclosures that occurred before \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ received and processed a written notice of revocation. I understand that if I did not specify duration and if I do not revoke it, this authorization will expire one year from the date of signature below.

ACKNOWLEDGEMENT

**Please sign and date**: I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to release nonpublic personal health information. I understand that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

 Participant’s Name (Print) Participant’s Signature Date

If you are not the participant, please also complete, sign and date below. Check the box that describes your relationship to the participant. Please attach proof or your relationship to the participant (e.g. Power of Attorney, Legal Guardian).

By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

 Participant’s Name (Print) Participant’s Signature Date

 □Parent of Minor Child □Legal Guardian □Power of Attorney □Executor □Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_