Center for Family Medicine

Authorization For the Use of Disclosure of Health Information

Date Needed By: _____

Patient Information	Name:_____ Date of Birth:_____ Address:_____ Phone:_____ City/State/Zip_____
Provider (Who is releasing the information)	Provider/Facility_____ Address:_____City/State/Zip_____ Phone:_____Fax:_____
Disclose Information to: (Where information is to be sent)	Provider/Facility_____ Address:_____City/State/Zip_____ Phone:_____Fax:_____
Information to Disclose	___All Records ___History/Physical ___Lab Reports __X-Ray Reports ___ X-Rays ___Visit/Progress Notes ___Other_____
Purpose of Disclosure	__At the request of the undersigned individual __Other_____
Expiration Date	This authorization expires in one year, unless otherwise indicated below: _____
Revocation	I understand that I may revoke this authorization at any time by sending a written notice to the health care facility/provider noted above. However, the revocation is not valid if: (1) action was previously taken in reliance on this authorization; or (2) this authorization is obtained as a condition for obtaining insurance coverage; other law provides the insurer with the right to contest a claim under the policy or the policy itself.
Authorization	I hereby authorize the able facility/provider to disclose medical information concerning the above named patient to the party identified in the section entitled "Disclose Information To." I understand that the information to be released may include information regarding mental health, alcohol/drug usage, and HIV-related information. I understand that once the information is disclosed, it may be subject to re-disclosure by the recipient and ma no longer be protected. I understand this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits.
Signature of patient/representative_____ **Date**_____ _____ Relationship to patient if signed by representative. Please supply proof of authority to act. For minors, proof only required if other than parent.	
Disposition	For office use only: Date sent:_____ Sent by: _____ __Authority to act attached __ID Validated Patient#/Chart#_____