



Please Print
Patient Name _____ Patient D.O.B. _____
Patient Address _____ Patient Phone# _____

You are hereby authorized to disclose my Protected Health Information whether oral, written or electronic healthcare information pertaining to my complete medical record, including but not limited to HIV and AIDS confidential information. You are hereby authorized to disclose my Protected Health Information specifically pertaining to my mental health, including but not limited to; psychiatric and physiological information, drug and alcohol abuse, and treatment information.

You are hereby authorized to disclose such Protected Health Information to any physician, healthcare provider, or healthcare care facility that has provided healthcare services to me. Additionally you are hereby authorized to disclose such Protected HealthCare Information to any attorney at law representing such physician, health care provider or healthcare facility.

Discussions related to my care. You are hereby authorized to discuss my care and treatment with any attorney or representative of an insurance provider if I assert a claim against another physician or healthcare provider, healthcare facility, or health care entity.

This authorization expires one (1) year after the execution date below.

Patient Rights

I understand I do not have to sign this authorization to receive healthcare benefits (treatment, payment, or enrollment) from the person(s) to whom this authorization is directed. I may revoke this authorization in writing at any time. If I do so, it will not affect any actions already taken by someone in reliance in this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance coverage. If I choose to revoke this authorization, I shall do so by sending a letter to the person(s) to whom this authorization is directed. Once the health care provider discloses information any person or organization that receives may re-disclose it.

_____ Date _____
Patient or Legally Authorized Individual Signature

_____ Relationship of signing individual (Self, Parent, Legal Guardian, etc.)

Protected Health Information is requested from:

Address _____ Phone number _____

_____ Fax number _____

Please provide Protected Health Information to:

_____ Phone # _____

_____ Fax # _____

() Transfer Care () Out of town move () Consult
() Insurance () Legal () Personal () Referring Physician

In office Healthcare Provider and Staff use only

_____ Provider Review/Date _____ Billing _____ Legal _____ Consult / Mailed or Faxed _____