# Authorization for Release of Personal Information

Member Name: _____

Member Address: _____

Member Telephone: (  ) _____

**This authorization allows the recipient to use or disclose my protected health information (PHI) for the following purpose:** _____

_____

**I request and authorize _____ to release personal information to:**

Name: _____

Address: _____

City, State: _____ Zip Code: _____

Telephone: (  ) _____

**This request and authorization applies to the type and amount of information to be used or disclosed as follows: (include dates where appropriate)**

☐ Problem List ☐ Medication List ☐ List of Allergies ☐ Immunization Record

☐ Most recent history and physical ☐ Most recent discharge summary

☐ Laboratory results from (date)_____ to (date) _____

☐ X-ray and Imaging reports from (date)_____ to (date) _____

☐ Consultation Reports ☐ Entire Record

☐ Other _____

**I understand that:**

- I understand that the information in my health record may include information relating to sexually transmitted disease, AIDS or HIV. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
- I may withdraw my authorization at any time by submitting a written request to the Health Information Management Department. If I do, I understand that my personal information my have already been released after I gave permission. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal or state privacy laws.
- I understand that this authorization will automatically expire on the following date, event or condition: _____ If I fail to specify an expiration date, event or condition, this authorization will expire in six months.
- I understand that I have the right to refuse to sign this authorization and that my refusal will not result in the condition of treatment, payment, and enrollment in my employers group health plan or eligibility for benefits. I understand that I may inspect or copy the information to be used or disclosed.

I have carefully read and understand the above and have had any questions explained to my satisfaction. I do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of my condition to those persons or agencies listed above.

Member (or personal representative) signature: _____

Print name: _____

Date: _____

**If signed by member's personal representative, please attach documentation of authority (e.g., power of attorney, signed authorization).**

***Mail Completed Form to:*** _____

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