

Authorization for Disclosure of Health Information

- (1) I hereby authorize _____ to disclose the following information from the health records of:

Patient Name: _____ Date of Birth _____

Home Address: _____ Home Telephone _____

University Address: _____ University Telephone _____
_____ Patient Number: _____

covering the period(s) of healthcare:

From (date) _____ To (date) _____
From (date) _____ To (date) _____

- (2) Information to disclosed:

- | | |
|---|---|
| <input type="checkbox"/> Complete health record(s) | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Health Report Form | <input type="checkbox"/> Laboratory Tests |
| <input type="checkbox"/> Immunizations | <input type="checkbox"/> X-Ray Reports |
| <input type="checkbox"/> Women's Health Records | |
| <input type="checkbox"/> Other (please specify) _____ | |

Please indicate if you want the following information released if applicable.

- Yes No Acquired (Immunodeficiency Syndrome AIDS) or infection with HIV (Human Immunodeficiency Virus)
- Yes No psychiatric conditions and care
- Yes No treatment for alcohol and/or drug abuse
- Yes No pregnancy
- Yes No sexually transmitted disease treatment
- Yes No abuse issues

- (3) This information is to be disclosed to _____ for the purpose of _____.

- (4) I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____

- (5) The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signed: _____
(Patient) (Date)

or (Legal Representative) (Relationship to Patient) (Date)