AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize_____ (name of doctor) and their staff to disclose my individually identifiable health information as described below. I understand this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Patient Name: _____ DOB: _____

Person/Doctor/Organization receiving this information:

_____

Description of information to be disclosed: _____

By signing below, I acknowledge the following:

- The healthcare provider requesting authorization will not receive financial Compensation in the exchange for disclosing this health information.
- I understand that my health care and my health care payment will not be affected if I do not sign this form.
- I understand I may see and copy the information described on this form if I ask for it, and that I will receive a copy of this form after I sign it, if I ask for it.
- I understand that this authorization will expire year months from the date on this form.
- I understand that I may revoke this authorization at any time by notifying the doctor in writing but if I do, it will not have any affect on any actions take before the receipt of the revocation.
- The health care provider requesting this authorization will not condition my teat meant on whether I provide authorization for the requested disclosure except if my treatment is related to research, or health care services are provided to me solely for the purpose of creating protected heath information for disclosure to a third party.

Signature of Patient or Guardian: _____

Date: _____ Printed Name: _____