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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

BY SIGNING THIS FORM, YOU PERMIT THE HEATH CARE PROVIDER IDENTIFIED BELOW TO DISCLOSE YOUR CONFIDENTIAL PERSONAL HEALTH INFORMATION. IT WILL TAKE 7 TO 14 BUSINESS DAYS TO PROCESS THIS RELEASE.

1. PATIENT/INSURED. The patient/insured whose information may be released is:
   NAME_____DATE OF BIRTH_____
   ADDRESS_____
   PHONE #_____ACCOUNT OR POLICY# (IF KNOWN)_____

2. PERSONAL HEALTH INFORMATION. Disclose the following documents of dates of service (be specific) _____
   _____

   - □ Entire medical record (past 2 years unless specified)
   - □ Laboratory reports
   - □ Radiology films
   - □ Hospital records
   - □ Itemized statements/billing records
   - □ Treatment/office exam notes/progress records
   - □ Radiology reports/diagnostic test results
   - □ Medication orders
   - □ Consultation reports/other outside provider records
   - □ Specified_____

3. SPECIAL LIMITATIONS. Does this Authorization exclude (check all that apply):
   - □ HIV/AIDS test results (if part of the specified record)
   - □ Drug/Alcohol use/abuse
   - □ Mental health treatment
   - □ Other exclusions (be specific) _____

4. DISCLOSING PROVIDER. The following provider may *disclose* the personal health information:
   Provider_____
   Address_____
   Phone_____

5. RECIPIENT. The following persons or organizations are to *receive* the personal health information:
   Provider_____
   Address_____
   Phone_____

6. PURPOSE OF DISCLOSURE. The reason I am authorizing release is:
   □ My request □ Other (describe):_____

7. EXPIRATION. This Authorization expires (periods longer than 180 days may not be accepted):
   Date:_____ OR Event:_____

8. EXPLANATION OF RIGHTS. I understand that:
   - × I can revoke this Authorization at any time by giving my written revocation to the Disclosing Provider. My revocation is not effective as to disclosures already made and actions already taken in reliance upon this Authorization.
   - × The disclosing provider may NOT condition treatment, enrollment in the health plan or eligibility for benefits on whether I sign this Authorization.
   - × I am authorizing disclosure of information protected under federal law. This information, once disclosed, any be subjected to re-disclosure by the recipient and no longer be protected by state of federal law.

_____ _____
Signature of Patient/Insured or Personal Representative Date

_____ _____
Representative's Relationship to Patient/Insured (if applicable) Representative's Printed Name

Interpreter's statement:
I have read him/her the authorization form in _____ and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation. _____