Sample Authorization for Release of Information

Sample Authorization to Use or Disclose Health Information

Patient Name:____

Date of Birth:____

1. I authorize the disclosure of the above named individual's health information as described below.

2. The following individual(s) or organization(s) are authorized to make the disclosure:

3. The type of information to be disclosed is as follows (Check the appropriate boxes and include other information where indicated.)

- ☐ Problem list
- ☐ Medication list
- ☐ List of allergies
- ☐ Immunization records
- ☐ Most recent history
- ☐ Most recent discharge summary
- ☐ Lab results (Please describe the dates or types of lab tests you would like disclosed.):
- ☐ X-ray and imaging reports (Please describe the dates or types of x-rays or images you would like disclosed.):
- ☐ Consultation reports from (Please supply doctors' names.):
- ☐ Entire record
- ☐ Other (Please describe.):

- ☐ Information related to treatment for any sexually transmitted disease, including HIV or AIDS*
- ☐ Information related to treatment for mental health-related illnesses*
- ☐ Information related to treatment for substance abuse*

**Must be checked for that specific information to be released.*

4. The information identified above may be used by or disclosed to the following individuals or organization(s):

Name:

Address:

5. This information for which I'm authorizing disclosure will be used for the following purpose:

- ☐ My personal records
- ☐ Sharing with other healthcare providers as needed
- ☐ Other (Please describe.):

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that 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.

7. This authorization will expire in (insert date or event):

If I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed.

8. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

9. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

____ ____________________
Signature of Patient or Legal Representative Date

If signed by legal representative, relationship to patient ___________________________________

____ ____________________
Signature of Witness Date

Distribution of copies: Original to provider, copy to patient, copy to accompany use or disclosure