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AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

Individual's name: _____

Home Address: _____

Home Telephone: _____Date of Birth_____

SPECIFY INFORMATION TO BE DISCLOSED: (e.g., abstract, lab results, etc.)

_____

SPECIFY ANY INFORMATION THAT I DO NOT WISH TO BE DISCLOSED:

_____

☐ Name of person, entity or class of person authorized to release the above information:

_____

☐ Name of person or class of persons to whom you may release the information to:

_____

Address of where my health information should be delivered:

_____

TERM: This authorization will remain in effect for one year from the date of signature unless otherwise noted.

PURPOSE: I authorize my health information (including highly confidential information unless I specify otherwise) to be sent to or by the Facility and it may be used and disclosed during the term of this Authorization.

I understand that once my health information is disclosed, there is no guarantee that the Facility or the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I also understand that my record may contain information regarding my mental health, HIV/AIDS, genetic information, venereal disease information, tuberculosis information, or information regarding drug and/or alcohol testing or treatment. By signing this authorization, if I request release of my records, I am authorizing release of any of the above information as well as any other information that may be included in my records. If I do not wish any of this information (or any other information) released, I will note the above under "specific information that I do not wish to be disclosed."

I know that I may refuse to sign or may revoke (at any time) this authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at the Facility or the entity sending the information (if applicable. Except, however, if my treatment at the Facility is for the sole purpose of creating health information for disclosure to the recipient identified in this authorization, in which chase the Facility may refuse to treat me if I do not sign this authorization. In addition, ONLY if my treatment is related to my participation in a research study, I understand that the Facility may refuse to treat me if I do not sign this authorization, and that this authorization will have no expiration date.

If I wish to revoke this Authorization before the above termination date) which is one year from when I sign this authorization unless I note otherwise, or if my treatment is related to my participation in a research study), I must provide a written notice to the Privacy Officer. Revocation will not have any effect on any action the Facility has already taken in reliance on this Authorization before it received my written revocation.

_____

_____

I have read this Authorization and have had a chance to ask questions about the use an disclosure of my health information. By signing below, I voluntarily authorize the Facility to use or disclose my health information in the manner described above.

_____ _____

Signature of Patient of Patient's Parent, Guardian or Representative Date

If authorization is signed by a patient's parent, guardian or representative, please complete the following:

_____

PRINTED NAME OF PATIENT'S REPRESENTATIVE

_____

RELATIONSHIP TO THE PATIENT

*****YOU MAY REFUSE TO SIGN THIS AUTHORIZATION*****