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Authorization Form for Release of Confidential Health Information

I, _____ hereby authorize _____
(NAME of PATIENT or AUTHORIZED AGENT) (NAME of PHYSICIAN, PHYSICIAN'S GROUP, or HOSPITAL)

the right to release health records to: _____
(NAME of HEALTH CARE FACILITY, PHYSCICIAN, AGENCY, ETC.)

_____
(STREET ADDRESS, CITY, STATE, and ZIP CODE)

The following information contained in the patient records of: _____
(PATIENT'S NAME)

_____
(DATE of BIRTH)

_____
(SOCIAL SECURITY NUMBER)

Residing at: _____
(STREET ADDRESS, CITY, STATE, and ZIP CODE)

- o The entire medical record, excluding mental health treatment, alcoholism treatment, drug abuse treatment, and HIV/ acquired immune deficiency syndrome (AIDS) records
- o Stress Test
- o Cardiac Catheterization Report
- o Angioplasty Report
- o EKG
- o Echo Report
- o Holter and /or Event Report
- o Surgical Report
- o Laboratory Report
- o X-Ray Report
- o Tests done in the last month
- o Tests done in the last year
- o Other: _____

The above information for the following period of time shall be released:
From: _____ to _____
Date Date

The purpose(s) of the authorization is (are) _____ I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above described information, I understand that it will not be disclosed, except as provided by law. understand that the practice may not condition treatment on whether I sign authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party. Understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by law.

Signed: _____ Date: _____
(IF YOU ARE NOT THE PATIENT, PLEASE SPECIFY YOUR RELATIONSHIP TO THE PATIENT)