

[Your firm name and logo]

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient: [Full legal name] | Date of birth: [MM/DD/YYYY] | Other names used: [Names]

Address: [Street, city, state, ZIP] | Phone: [Phone] | Record number, if known: [MRN]

Provider or plan releasing records: [Name, address, records department fax or phone]

Recipient: [Person or organization, contact name, address, phone]

Information to be disclosed

I authorize the provider named above to disclose the following records dated from [start date] to [end date]: [] office and visit notes [] discharge summaries [] lab and test results [] imaging reports and images [] medication and pharmacy records [] itemized billing records [] other: [describe]. This authorization does not cover psychotherapy notes.

Sensitive records (initial each line you include) (optional)

[Initials] Substance use disorder treatment records (a federally assisted program may require its own 42 CFR Part 2 consent; SUD counseling notes are not included). [Initials] HIV or AIDS test results and treatment. [Initials] Mental health records other than psychotherapy notes. [Initials] Genetic test results. If a line is not initialed, that information is not released.

Purpose

The information will be used for: [] at the request of the individual [] a legal claim or case: [matter] [] insurance application or claim: [policy or claim number] [] other: [describe].

Expiration

This authorization expires on [date] or when the following event occurs: [event, such as the conclusion of my claim], whichever comes first.

Right to revoke

I may revoke this authorization at any time by writing to [provider name and records address]. Revoking it does not affect any action the provider took in reliance on it before receiving my written revocation. If I signed it as a condition of obtaining insurance coverage, other law may still give the insurer the right to contest a claim under the policy or the policy itself.

No conditioning

My treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned on whether I sign this authorization.

Consequences of refusing to sign (alternative) (optional)

Use instead of the no-conditioning statement only where 45 CFR 164.508(b)(4) lets the requester condition research-related treatment, enrollment or eligibility before enrollment, or an exam done only for a third party: If I do not sign, [consequence, such as: the plan will not process my enrollment / the exam for (third party) will not take place].

Redisclosure

Information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by federal privacy rules.

Delivery (optional)

Please send the records to the recipient as: ☐ paper copies by mail ☐ an electronic copy ☐ images on disc.

Copy

I understand I am entitled to a copy of this signed authorization.

_____ Date: [MM/DD/YYYY]

Signature of patient or personal representative

Printed name: [Name]

If signed by a representative, authority to act for the patient: [Parent / guardian / health care power of attorney / executor], document attached: ☐ yes