HIPAA Authorization/ Medical Release of Information

HIPAA Regulations require this Facility to obtain an authorization for certain disclosure. Please read and sign the below, if you wish to approve this authorization.

Who is requesting information?

Patient Name:_____ Date of Birth:_____

Address:_____ City/State/Zip_____

Phone:_____

What information is going to be used or disclosed?

Who will be the recipient of this information?	What facility is this information requested from?
Name: _____	Name: _____
Address:_____	Address:_____
Phone:_____ Fax:_____	Phone:_____ Fax:_____ *I authorize the above to use and disclose a copy of the specific health information described above.

What is the purpose of this use and/or disclosure?

Continuation of Care/Transition of care

When will this Authorization expire? **2 years after signature obtained**. This authorization expires on:_____

I understand this authorization is voluntary and that if I refuse to sign, it will not affect my ability to receive treatment, payment or eligibility of benefits, except in the following:

- The treatment is research-related
- Enrollment into a health plan, if to determine eligibility and it is not for uses or disclosure of psychotherapy notes
- The sole purpose of the Authorization is to create Protected Health Information that will be disclosed to a third-party

I understand that the information being released may include: alcohol and drug abuse/treatment; psychological and social work counseling; HIV, AIDS or ARC; communicable disease or infections, including sexually transmitted disease, venereal disease, tuberculosis and hepatitis; genetic information and demographic information for the purposes designated on this form. **Initial:_____**

If the recipient is not covered by the HIPAA Regulations, then the information disclosed may not be further protected.

Sign and date below to acknowledge that you are accepting this Authorization of Use and/or Disclosure	
Patient Signature	Date
Printed Name	Date of Birth

You may revoke this Authorization at any time in writing by sending a written notification to the Facility or you may complete the revocation notice below and return it to the Facility.

By completing the below, I request that this Authorization be Revoked. I understand that this revocation will not apply to any uses or disclosures that have already occurred.	
☐ I am requesting the revocation of this Authorization	
Patient/Personal Representative Signature	Date
Printed Name if Not the Patient	Relationship