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Authorization for Release of Information

I, hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations.

Patient Name: _____ DOB: _____

Records requested from: **Please include any labs, tests and office notes.**

_____

_____

_____

Records requested to:

_____

_____

_____

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire 90 days from today. _____ **(initial)**
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any affect on any actions they took before they received the revocation. _____**(initial)**

_____

Signature of the patient or the patient's representative **Date**

_____

Printed name of the patient or the patient's representative - Relationship to patient