AUTHORIZATION FOR RELEASE OF INFORMATION

Section A: Must be completed for all authorizations

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 informatior is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient name: _____ **ID Number**: _____

Persons/organizations providing the information:

_____
_____
_____
_____

Persons/organizations receiving the information:

_____
_____
_____
_____

Specific description of information (including date(s)): _____
_____
_____
_____
_____

Section B: Must be completed only if a health plan or a health care provider has requested the authorization

1. The health plan or health care provider must complete the following:
   a. What is the purpose of the use or disclosure?:_____
   _____
   b. Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes_____ No_____

2. The patient or the patient's representative must read and initial the following statements:
   a. I understand that my health care and the payment for my health care will not be affected if I do not sign this form. Initials: _____
   b. I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it. Initials: _____

Section C: Must be completed for all authorizations

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

1. I understand that this authorization will expire on __ __/__ __/__ __ __ __ (DD/MM/YR) Initials: _____
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. Initials: _____

_____ _____

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

(Form MUST be completed before signing.)

Printed name of patient's representative: _____

Relationship to the patient: _____

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

You may not use this form to release information for treatment or payment except when the information to be released is psychotherapy notes or certain research information.