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AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Name: _____
Last First Middle

Date of Birth: _____

Authorization for Use/Disclosure of Information: I voluntarily authorize and direct the health care provider named below to disclose my health information during the term of this authorization to the recipient that I have identified below.

Name of Provider: _____

Address of Provider: _____

Tel #: _____

Fax#: _____

Recipient and Address for Delivery of Records:

Purpose: I understand that the specific purpose of this authorization is:

Information to be disclosed: This authorization permits the above named health care provider to disclose the following medical records.

All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me, including without limitation, x-rays, HIV/AIDS status, genetic testing, psychotherapy notes, billing information, correspondence, and records from my other healthcare providers that the above-named health care provider may hold.

All of my healthcare information described above except for the following:

Only the following records or the types of health information: (Insert dates of treatment, types of treatment or other designation.)
