

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the release of my individually identifiable health information as described below. I understand this authorization is voluntary and that I may refuse to sign this authorization and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.

Name: _____

ID Number: _____

Address: _____

Persons/organizations authorized to receive the information:

Specific description of information to be used or disclosed including dates:

Specific purpose of the disclosure:

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation will not have any effect on any actions that the entity took before it received the revocation.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive my health care benefits.
- The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving entity.

Signature of patient or patient's representative

Date

(Form MUST be completed before signing)

Printed name of the patient's personal representative: _____

Relationship to the patient, including authority for status as representative: _____

No one requesting or releasing this authorization will receive financial or in-kind compensation in exchange for using or disclosing the health information described above.