**Authorization to Release Health Information**

**Patient Information:**

Name of Patient Date of Birth

Address City, State, Zip Phone

# may release the following information:

(Name of the entity)

### Entire record  Financial records  Office visit notes

* X-rays

**Entity or person who will receive the information:**

Name Address

City, State, Zip Phone

# Send the information electronically. Email address:

* For **email communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to move forward to allow email communications to occur.

# This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

**Patient Rights:**

* I have the right to revoke this authorization at any time by contacting our office.
* I may inspect or copy the protected health information to be disclosed as described in this document.
* Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
* Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
* I may refuse to sign this authorization and that my treatment will not be conditioned on signing*.*
* I understand released information may include a communicable disease diagnosis such as HIV.

## Date

Signature of Patient or Personal Representative

Description of Personal Representative’s Authority (attach necessary documentation)

Revised Jan 2018

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