

Authorization for Disclosure of Health Information

1. I hereby authorize (releasing facility) _____ to disclose the following information from the health records of:

Patient Name: _____ Date of Birth: _____

Address: _____

Soc. Sec. # _____ Telephone: _____ Med. Rec. # _____

2. **Dates of treatment/visit:**

From (date) _____ to (date) _____

3. **Information to be disclosed:**

- complete health record
- discharge summary
- history & physical
- consultation report (s)
- lab report (s)
- x-ray report (s)
- cardiopulmonary report (s)
- other (please specify) _____

Information disclosed to:

Purpose of Release: _____

I understand that this will include information relating to (**check if applicable**):

- Acquired immunodeficiency syndrome (AIDS) or infection with human immunodeficiency virus (HIV)
- Behavioral health services/psychiatric care
- Treatment for alcohol and/or drug abuse

4. I understand that my records are protected under the State and Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire in 90 days from the date of my signature.

The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information other than to the extent indicated and authorization herein.

Signature of patient / legal representative

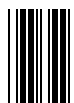
114178 Rev. 5/03

Date

Confirmed ID _____

DOB: // Admit: // :00

Physician: , _____



ADHIGNRL

