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AUTHORIZATION FORM FOR RELEASE OF MEDICAL RECORDS

I hereby authorize the use and disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. Any health information disclosed pursuant to this authorization may be subject to re-disclosure by the recipients and may no longer be protected by the Federal privacy regulations.

Patient Name: _____ Social Security Number: _____

Persons/Organizations authorized to use/disclose or receive my information:

_____

_____

_____

Specific description of the information to be used to disclosed (including date(s)):

_____

_____

Description of each purpose of the use or disclosure of my health information:

At the request of the patient,

I understand that this authorization will expire on: _____ Initials: ____

I understand that I may refuse to sign this form and that my health care and the payment for my health care will not be affected if I do not sign this form. Initials: ____

I understand that I will get a copy of this form after I sign it. Initials: ____

I understand that I may revoke this authorization at any time by notifying the Practice in writing, but if I do, the revocation will not have any effect on the actions the Practice has already taken in reliance on this authorization. Initials: ____

Signature of Patient: _____ **Date:** _____

If this authorization is signed by a patient's representative, please complete the following:

Print Name of Patient's Representative: _____

Relationship to the Patient: _____