AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

NAME OF INDIVIDUAL/PATIENT	
DATE OF BIRTH	
ADDRESS	CITY/STATE/ ZIP

1. I hereby voluntarily authorize ____ to disclose the medical information indicated below to ____.

2. The purpose for this disclosure is for ____.

3. The information to be disclosed is:

___ Entire Medical Record
___ Only medical information from the period ________________ to _______________.
___ Other (specify) _________________________

If you would like any of the following sensitive information disclosed, please indicate with a check mark below:
___ Alcohol/ Drug Abuse Treatment
___ HIV/ AIDS- related Treatment
___ Mental Health (other than psychotherapy notes*)

4. This authorization shall become effective immediately and shall remain in effect until ____________ (date) or for one year from the date of signature if no date is entered.

I understand that I may revoke this authorization in writing at any time prior to the release of information from DPH, and that revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

I understand that my eligibility for benefits, treatment or payment is not conditioned upon my provision of this authorization.

I understand that information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act.

____
Print Patient's Name

____
Patient's Signature

____
Print Authorized Representative's Name (if applicable)

____
Authorized Representative's Signature (if applicable)

____
Date

**Psychotherapy notes* means notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. 45 C.F.R. 164.501.