Authorization for Use and Disclosure of Protected Health Information

Patient Name: ________________________________ Date of Birth:
Phone Number: ________________________________

Release Records From:

Doctor/Clinic:____________________
Address:____________________
Phone:____________________
Fax:____________________

To Be Sent To:

Doctor/Clinic:____________________
Address:____________________
Phone:____________________
Fax: ____________________

Information to be disclosed (check all that apply):
☐ Clinical Notes
☐ Radiology Reports, last 2 years
☐ Laboratory Tests (TB-Hep B/C), last 2 years

Please do **NOT** send health information related to (check all that apply):
☐ HIV (AIDS) ☐ Drug/Alcohol Abuse ☐ Sexually Transmitted Disease (STD) ☐ Mental Health

Reason for disclosure
I authorize the use or disclosure of my health information as described above for the purpose listed.

____________________________________ ____________________
Signature of Patient or Legal Representative Date

____________________________________ ____________________
Print Name (if other than patient) Relationship to Patient