AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize [insert practice name] to receive information from the above named patient’s medical records, including laboratory results, radiologic testing results, medications, hospitalization information, office notes, and treatment plans for the purposes of continued care. I understand that this authorization will expire in 90 days, and that it may be revoked at any time in writing. I further understand that continued treatment of the above-named patient is not contingent upon receipt of this information. Also, the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the HIPAA privacy rule.

Specific records being requested:

I acknowledge that my records may include sensitive material. Therefore, I request that you include the following records if any (initial by categories to be included in records provided):

­\_\_\_\_\_Substance Abuse \_\_\_\_\_AIDS/HIV/STDs \_\_\_\_\_Psychological/Psychiatric Conditions

\_\_\_\_\_Genetic Testing

Please send the requested information to:

[insert practice name]

[insert practice address]

Phone: [insert practice phone]

Fax: [insert practice fax]

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Signature of Patient or Legal Guardian Relationship