

Authorization to Release Health Information

Patient Information:

Name of Patient _____ Date of Birth _____

Address _____

City, State, Zip _____ Phone _____

At my request, _____ may release or receive the following information: Radiographs Office Visit Notes Financial Information

OTHER: _____

Entity or person who will release or receive the information:

Name _____

Address _____

City, State, Zip _____ Phone _____

 Send the information electronically. Email address: _____ For **email communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to move forward to allow email communications to occur.**This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.****Patient Rights:**

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis such as HIV.

Signature of Patient or Personal Representative_____
Description of Personal Representative's Authority (attach necessary documentation)