Authorization for Release of Information (To HTPN)

I hereby authorize ____ ____

Entity or Person **from** whom records are requested Address

______________________ ______________________ ____________________________ _______ ______________

Telephone Fax City State Zip

to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider; the released information may no longer be protected by federal and state privacy regulations.

____ _____________________ ___________________________

Patient Name (please print) Date of Birth Social Security Number

____ ___________________________

Patient Address (City, State and Zip) Phone Number

____

Specific Date(s) of Service (if known) All Dates of Service

Information to be released: (Check all that apply)

Complete Medical Records Radiology Reports & Films Registration Records Billing Records

Visits & Encounters Laboratory Reports Consultation Reports Emergency Room

Laboratory Reports Operative Records Other: ____

____

Description of the purpose of the use and/or disclosure:

The health information described herein shall be **released to**:

Category: Hospital Physician Insurance Company Attorney Patient Other_______________________

____ _____________________________

Name of Person or Entity (please print) Phone Number

____ _____________________________

Address (City, State, and Zip) Fax Number

Delivery Method: Mailing Address Fax Pick-Up Records Other_________________________________

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until___________________ (Expiration date/event).

I further understand that I may revoke this authorization at any time by notifying this practice in writing. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

____ _____________________

Signature of Patient, Parent, or Legal Guardian **Date**

____

Printed Name of Patient, Parent, or Legal Guardian

____ ____

Relationship to Patient **or** **Legal Authority** (Attach Supporting Documentation)