



AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION:

Please read this form carefully. The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) which became effective April 14, 2003, requires that all of the following elements must be completed for an authorization to be valid.

Patient Name _____ Date of Birth _____

Street Address _____

City, State, and Zip Code _____

Phone Number _____

Medical Record Number _____

I hereby authorize that the protected health information regarding the above-named person be forwarded:

From: Person/Organization _____

Address _____

City, State & Zip Code _____

To: Person/Organization _____

Address _____

City, State & Zip Code _____

Purpose or Need for Information _____

Disclosure will include (check all that apply)

Consultation Report

History & Physical

Laboratory Report

Progress/Physician Notes

Operative Report

Radiology Report

Pathology Report

Other _____

Records for the period (dates) from _____ to _____

Patient Signature _____ Date _____

Staff Signature _____ Date _____