

MEDICAL RECORD #: _____

PATIENT AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

PATIENT NAME: _____ : / /
Last First MI Date of Birth

The undersigned hereby authorizes disclosure of protected health information

FROM:	TO:
_____	_____
Institution or Individual	Institution or Individual
_____	_____
Street Address	Street Address
_____	_____
City/State/Zip	City/State/Zip

	Phone/Fax #

The purpose/need for the information is: _____

As to mental health or developmental disability information, only information relevant to the purpose for which disclosure is sought may be disclosed.

Information to be disclosed:

- Medical Record
- Billing Record
- Designated Record Set
- X-ray Films
- Other _____

Dates of service to be disclosed:

- Specific Date: _____
- Range of Dates: _____
- Any and All

Disclosures Requiring Special Authorization

By marking any of the boxes below, I specifically authorize the use or disclosure of information containing these categories of highly confidential information:

- Mental Health or Developmental Disabilities
- Substance Abuse (Drug/Alcohol)
- HIV/AIDS Testing or Treatment
- Sexually Transmitted Diseases

This authorization will expire 180 days from the date of signature unless a date or event prior to 180 days is specified: _____

(Enter the date or event that you request this authorization to expire)

