

Release of Information Form

Patient Information				
First Name	Last Name	Date of Birth	Gender	
Address		City	State	Zip Code
Email		Contact Number		
I. Authorization				
I authorize the following named individual or organization,				
Authorized Person/Organization				
Person/Organization Name		Contact Number		
Address				
City	State		Zip Code	
to use or disclose the following information related to the above named patient:				
☐ All Medical Information				
☐ Only Medical Information Related to _____				
☐ Medical Information from __/__/__ to __/__/__				
☐ Other: _____				
for the purposes of				
☐ Treatment/Continuing Medical Care				
☐ Personal Use				
☐ Billing or Insurance Claims				
☐ Legal Proceedings				
☐ Employment				
☐ Other: _____				
II. Disclosure				
I authorize this information to be shared with				
Receiving Person/Organization				
Person/Organization Name		Contact Number		
Address				
City	State		Zip Code	

Patient Information			
First Name	Last Name	Date of Birth	Gender
III. Expiration			
This authorization is valid until ☐ Authorization is revoked through written notice to the authorized person or organization ☐ The following date __/__/____ ☐ Other: _____			
IV. Statements of Rights			
- I understand that I have the right to revoke this authorization, in writing to the authorized person or organization, and at any time, except where uses or disclosures have already been made based upon my original permission. - I understand that uses and disclosures already made based upon my original permission cannot be taken back. - I understand I may not be able to revoke this authorization if the purpose was to obtain insurance. - I understand that it is possible that information disclosed under the terms of the authorization may be re-disclosed by a recipient and no longer protected by HIPAA privacy standards. - I understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether the individual signs the authorization - I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.			
Signature Authorization			
Patient Signature _____ Patient Name (Printed) _____ Patient Signature _____ Date			
Representative Signature _____ Representative Name (Printed) Authority to act on behalf of patient ☐ Parent of Minor ☐ Guardian ☐ Other: _____ _____ Representative Signature _____ Date _____ Minor Individual Signature (If Applicable) _____ Date			