Authorization for Release of Protected Health Information

I hereby authorize the use and disclosure of my individually identifiable health information as described below.

I understand that signing this authorization is voluntary and that if I refuse to sign this form it will not prevent receipt of health care or eligibility for benefits under a health plan.

I understand that I am entitled to receive a copy of this form upon signing it.

I understand that if the organization or individual authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

I understand that I have a right to revoke this authorization, but that I must send a written revocation to the address below. I also understand that the revocation applies to uses and disclosures made after the revocation is made.

Patient Name	ID Number

Person or organization authorized to release my health information:

Name	Phone Number

City	State	Zip

Person or organization authorized to receive my health information:

Name	Phone Number

City	State	Zip

Specific description of information that is to be disclosed (include dates):

Purpose of the disclosure:

This authorization will expire on (date or event):

Signature	Date

Patient Name (print):

If signed by a patient representative:

Representative Name (print)	Relationship to Patient and Authority Status

This form does not authorize the use of psychotherapy notes.