

# AUTHORIZATION FOR RELEASE OF INFORMATION

## Section A. Must be completed for all authorizations.

I hereby authorize the use or disclosure of my health information as described below. I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

Patient Name: \_\_\_\_\_

ID Number: \_\_\_\_\_

Persons/organizations providing the information:

Persons/organizations receiving the information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Specific description of information (including date(s)): \_\_\_\_\_

Medical records and bills, including, but not limited to, diagnostic reports

What is the purpose of the use or disclosure? \_\_\_\_\_

PATIENT RESEARCH

(Note: "at the request of the individual" is a sufficient description of the purpose when the patient initiates the authorization and elects not provide a statement of the purpose)

## Section B: Must be completed only if the healthcare provider has requested the authorization

1. The provider must complete the following statement:
  - a. Will the healthcare provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_
2. The patient must read and initial the following statement:
  - a. I understand that I get a copy of this form after I sign it. **Pt. Initials:** \_\_\_\_\_

## Section C: Must be completed for all authorizations

I understand that I have the right to refuse to sign this form and that my refusal will not result in the physician conditioning the provision of Healthcare with two exceptions: (1) refusal to sign this authorization, if it is for disclosure of information created for research that includes treatment, may result in the physician declining to provide the research-related treatment; and/or (2) refusal to sign this authorization, if it is for disclosure of information created for the sole purpose of disclosure to a third party, may result in the doctor declining to provide the healthcare which is for the sole purpose of creating protected health information for disclosure to a third party. **Pt. Initials:** \_\_\_\_\_

I understand that this authorization will expire on the following date: \_\_\_\_\_ or with the following event:

I understand that I may revoke this authorization at any time by notifying the healthcare provider in writing. The revocation will only be effective from the date it is received in this office and will not apply retroactively. **Pt. Initials:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_

**Signature of patient or patient's representative**

(pertinent sections of the Form MUST be completed before signing)

Printed name of patient's representative: \_\_\_\_\_

Relationship to the patient: \_\_\_\_\_