Authorization for Release of Health Information

Expires upon one time release

Patient Name: _____ DOB: _____

Address: _____

City, State, Zip: _____ Phone: _____

I authorize the practice listed below to release my health information:

Practice Name: _____

Address: _____ Phone: _____

City, State, Zip: _____ Fax: _____

Please forward/release my health information to:

_____

_____

_____

The information below is provided at the request of the patient. (Describe PHI needed)

_____

_____

Patient Information

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. *I understand that information disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.*

I understand that I have the right to revoke this authorization by sending a written notification to the address of the Doctors Care center above. I also understand that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification.

_____ Date: _____

Signature of Patient or Personal Representative

_____

Description of Personal Representative's Authority (attach necessary documentation)