AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I authorize_____
(Name and address of facility/health care provider you wish to release information)

To release information requested for (either DOB or SID is REQUIRED to identify record):

_____ **D.O.B.**_____ **S.I.D.**_____
(Name of person making request) **(Date of Birth)**

To: _____ **For the purpose of** _____

_____ _____

By INITIALING the spaces below, I specifically authorize the release of the following records, if such records exist:

____All hospital records (including nursing records and progress notes)
____Transcribed hospital reports **____Pathology reports** **____Other (Explain Below)**
____Medical records needed for continuity of care **____Diagnostic imaging reports** _____
____Most recent five year history **____Clinician Office Chart notes** _____
____Laboratory reports **____Dental records**
____Emergency and Urgency care records
____Please send the entire medical records (All information) to the above named recipient

I authorize the information listed below to be used, disclosed, or received by placing my INITIALS next to the information:

_____*HIV/AIDS – related records (Copies will not be released to inmates while incarcerated)
_____*Genetic testing information
_____* Mental Health-list specific info requested _____
_____ Alcohol and Drug information**

**PROHIBITED RE-DISCLOSURE: This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Must be initialed to be included in other documents. Records will not be released without your initials specifying that you have granted this specific release authority.

This authorization is limited to the following time period:_____
This authorization is limited to a worker's compensation claim injuries of:_____

My signature indicates that I authorize the disclosure of the above information and understand the following:

I understand that I may choose not to sign this authorization and that my choice not to sign will not be a basis to affect my ability to obtain treatment or my eligibility for health care benefits.

I understand I can cancel permission to use and disclose my information at any time in writing. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing, or shall remain in effect for the period reasonably needed to complete the request.

I understand this change will not affect information that has already been shared.

I understand that federal and state law protects my health information. However, my information could be shared with agencies or businesses that may not be covered by this law. They could then share my information with others. I understand that they cannot share information regarding HIV/AIDS, mental health treatment, alcohol and drug treatment or genetic testing unless I give them permission by initialing this permission above or as otherwise permitted by law.

_____ _____
(Signature of Patient) **(Date)**

_____ _____
(Signature of legal/personal representative authorized by law) **(Date)**