Authorization for the Disclosure of Health Information

Photocopy or facsimile of the original authorization will be considered as valid as the original.

Need for the disclosure:
- Changing physicians/relocation/moving
- Disability determination
- Legal investigation
- Personal (if acting as a personal representative of the patient, please state purpose of how you are acting on behalf of the patient):
  - Payment process/insurance/billing difficulties
  - Application insurance
  - Other:

Your rights with respect to this authorization

Right to Inspect or Copy the Health Information to be used or disclosed—I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the health information department. Right to Receive Copy of this Authorization—I understand that if I agree to sign this authorization, which I am not required to do so, I must be provided with a signed copy of the form. Right to refuse to sign this authorization—I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. Right to Withdraw this Authorization—I understand that written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the health information department. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have already made in reference to this authorization.

Expiration Date: This authorization is good until the following date(s) ____________ or for one year from the date signed. I have had opportunity to review and understand the content of this authorization form. By signing this authorization I am confirming that it accurately reflects my wishes.

Signature of Patient/Legal Representative: __________________________
Date: ____________________ (If signed by other than the patient, state relationship and authority in which to sign for the patient, i.e. deceased, minor, incompetent)

Request filled by: ____________________ (Employee) Date: ___________ Records Released: ___________