# Authorization to Release Protected Health Information

This authorization allows the use or disclosure of certain health information about you described below. Please complete all sections.

### Patient Information

Name:

_____

Date of Birth: _____ Address:

_____

Phone Number: _____

### Person/Facility Authorized to Disclose Information

Name/Facility:

_____

Address:

_____

Phone: _____

### Person/Facility Authorized to Receive Information

Name/Facility:

_____

Address:

_____

Phone: _____

### Description of Information to Be Disclosed

☐ All health records

☐ Only the following records or types of information:

_____

☐ Mental health/substance use records ☐ HIV/AIDS-related information

### Purpose of Disclosure

(e.g., continued care, insurance, personal)

I understand that I may revoke this authorization in writing at any time except to the extent that action has already been taken in reliance on this authorization. This authorization will expire on the following date or event:

Expiration date/event

I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the

recipient and no longer protected by federal privacy regulations.

Signature of Patient/Personal Representative:

_____

Date: _____

If signed by personal representative, state relationship to patient:

_____