Patient Authorization to Disclose Health Records

For Disability Claim

Patient Name:

Date of Birth:

Address:

Phone Number:

Medical Record Number (if known):

Recipient (e.g., Insurance Company, Agency):

Recipient Address:

Recipient Phone/Fax/Email:

Description of Records to Disclose:

Example: All medical records related to my disability claim from [date] to [date]

Purpose of Disclosure:

Disability benefit determination

Expiration Date or Event:

e.g., One year from signature; completion of claim process

I authorize the release of my health records as described above. I understand that I may revoke this authorization at any time in writing, except to the extent action has already been taken. I understand that disclosure of this information carries the potential for unauthorized re-disclosure and the information may not be protected by federal privacy rules. I am not required to sign this authorization, and treatment or payment will not be conditioned on my signing.

Patient/Authorized Representative Signature:

Date:

If signed by Representative, state authority (e.g., parent, guardian, POA):