

**AUTHORIZATION FOR RELEASE  
OF PROTECTED HEALTH INFORMATION**

**MEDICAL AUTHORIZATION**

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Social Security Number  
(optional)

I authorize \_\_\_\_\_ ("Health Provider") to disclose my protected health information as specified below. I understand that signing this Authorization is voluntary and that my treatment may not be conditioned on the signing of this authorization. I understand that I have the right to revoke this Authorization at any time by providing a signed, written notice of such revocation to Health Provider. I understand that I cannot revoke this Authorization to the extent this Authorization has been relied upon. I understand that information released pursuant to this Authorization may no longer be protected by law or regulation and may be redisclosed by the recipient.

1) (a) Please disclose the entire medical record including any and all medical information and opinions (whether written or oral), office notes pertaining to my physical or mental condition and physical or medical treatment rendered therefore, and allow \_\_\_\_\_ (insert name of recipient) or their representative to see and obtain copies of all records, notes, reports, X-rays, medical tests, studies, and correspondence, including correspondence to and from other medical providers and insurance companies regarding my condition and/or treatment.

(b) Health Provider cannot use or disclose certain information unless the patient specifically authorizes such use or disclosure. **Please initial next to each item below if you specifically authorize the release** of health information relating to the testing, diagnosis, or treatment for:

HIV/AIDS

Drug and alcohol abuse

Mental health/ psychiatric disorders

- 2) All information maintained at any time by Health Provider may be disclosed.
- 3) The information requested by this Authorization may be received by \_\_\_\_\_ (insert name and address of recipient).
- 4) The information is being requested for the purposes of discovery during litigation between \_\_\_\_\_ (insert parties' names).
- 5) Unless revoked earlier, this Authorization will expire at the resolution of the litigation, whether by settlement, verdict or judgment, inclusive of the period of time for any appeal.

By signing below, I understand and acknowledge the following:

- I have read and understand this Authorization;
- I have been given a copy of this Authorization;
- I am authorizing Health Provider to use or disclose my health information to the persons and for the purposes identified in this Authorization; and
- If I have any questions about disclosure of my protected health information pursuant to this Authorization, I may contact Health Provider.
- **A photocopy of this authorization shall be considered as effective and valid as the original.**

Print Name	Signature of Patient or Personal Representative	Date
------------	--	------

If signed by the patient's personal representative, describe the legal authority of the representative to act on behalf of the patient \_\_\_\_\_.

Legal authority of representative verified by \_\_\_\_\_.