



Authorization for Release of Medical Information

Patient Name: _____ Date of Birth: _____
 Phone #: _____ SSN: _____
 Street Address: _____
 City: _____ State: _____ Zip Code: _____

I authorize _____

to release information from the medical records of: _____

To: _____

- Individual
- Organization
- Address
- City, State, Zip

For the purpose of: _____

Type of Access Requested:

___ Physician/Clinic Office Notes ___ Labs ___ Counseling ___ Case Management Other: _____

For the specified time period of: _____

I acknowledge and hereby consent to such, that the released information may include, but not limited to:

Diagnostic Information	Substance Use History	Treatment History
Medications & Dosages	Trauma History	Program Participation & Com
Lab Tests & Results	Employment Status	HIV/AIDS Testing & Results
Living Situation & Social Supports	Allergies	

- I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 CFR Part 2, and Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.
- I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent automatically expires as follows:

- I understand that my care, payments, benefits or eligibility to enroll in a benefit program will not be affected by refusal to sign this authorization for release of medical information.
- I understand that information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient. This physician practice is released and discharged of any liability and the undersigned will hold the physician practice harmless for complying with "Authorization for Release of Medical Information".
- Fees/Charges will comply with all laws and regulations applicable to release of information

 Signature of Patient/Parent/Conservator/Guardian

 Date

 Agency Witness

 Date