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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____ , hereby authorize _____
(Name of Patient) *(Name of person or facility which has information)*

to release the following health information:

_____

To: _____
(Name and title or facility name to receive health information)

_____
(Street Address, city, state, ZIP code)

_____ _____
(Telephone Number) *(Fax Number)*

For the following purposes:

_____

This authorization is in effect until _____ , when it expires.
(Date or Event)

I understand that by signing this authorization:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtain

Signed by Patient:	*Date*
Or Signed by Personal Representative: _____ *On Behalf of (print name of patient)* _____	*Date*