

Authorization to Release Health Care Information

Patient's name: _____

Date of birth: _____

SSN: _____

Previous Name: _____

I request and authorize _____ to release health care information of the patient named above to:

Name: _____

Address: _____

City, State: _____ Zip code: _____

Institutional Affiliation: _____

This request and authorization applies to:

_____ Health care information relating to the following treatments, condition or dates of treatment. _____

_____ All health care information

_____ Other: _____

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus). Sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.

Signature of patient or patient's authorized representative
signed

Date

Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER THE DATE IT IS SIGNED

Last Update 02/03/2010