# Authorization For Release of Information

**I. Information about the Use or Disclosure**

I hereby authorize the use or disclosure of my individually identifiable health information as described below. *This authorization is provided voluntarily.*

Patient Name: _____ ID Number: _____

Persons/organizations authorized to provide the information: _____

Persons/organizations authorized to receive the information: _____

Specific description of information to be used or disclosed (including date(s) if applicable: _____

_____

Specific purpose of the disclosure (e.g., "at individual's request") _____

Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above?

No _____ Yes (describe) _____

This authorization will expire _____ (indicate date or event such as termination).
NOTE: Unless an earlier date is otherwise specified, this authorization will expire upon termination of employment or 2 years following the date authorization was provided (whichever is earlier).

**II. Important Information About Your Rights**

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration by notifying the providing organization in writing, but revocation will have no affect on any actions the entity took before receiving the revocation.
- I may see and copy the information described on this form if I have for it.
- I may not be required to sign this form to receive my health care benefits (enrollment, eligibility, treatment, or payment). However, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied fi authorization is given.
- The information authorized to be used or disclosed may be redisclosed by the receiving entity.
- I understand that if my record contains information relating to HIV infection, AIDS, or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing, this disclosure will include that information.

**III. Signature of Patient or Patient's Representative**

_____ _____
Signature of patient or patient's representative Date

Printed name of the patient's personal representative: _____

Relationship to the patient, including authority for status as representative: _____

***YOU MAY REFUSE TO SIGN THIS AUTHORIZATION***