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AUTHORIZATION FOR DISCLOSURE OF PATIENT MEDICAL INFORMATION

Patient's Name_____ **Date of Birth** _____
Address _____ **Phone:**_____
_____

I hereby authorize use of disclosure of protected health information about me as described below:

From:

Name: _____
Address: _____
_____
Phone: _____ **Fax:** _____

To:

Name: _____
Address: _____
_____
Phone: _____ **Fax:** _____

The *specific* information that should be disclosed is: Dates from_____**to**_____

- **( ) Office Notes**
- **( ) Lab Results (In-Office)**
- **( ) Procedure Results – (Radiology, Cardiology, In-Office)**
- **( ) Xray Films (In-Office)**
- **( ) Consultations**
- **( ) Research Study Visits**
- **( ) Other (Specify):**_____

I understand that the information used or disclosed may be subject to re-disclosure by the entity receiving it and would then no longer be protected by federal privacy regulations.

I understand that I have the right to revoke this Authorization, if the revocation is in writing, except if:

- *** This office has taken action reliant upon this Authorization**
- *** This Authorization was given as a condition of obtaining insurance coverage**

I understand that I may revoke this Authorization by delivering written notice.
This Authorization expires one year from the date signed.

_____
Signature of patient or authorized Representative **Date**

_____
Signature of Witness **Date**