AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name:_____

DOB:_____Social Security #: _____ Medical Record #:_____

I authorize the following provider(s) to release health information:

*1)*_____
Name of provider

_____
Address

*2)*_____
Name of provider

_____
Address

*3)*_____
Name of provider

_____

*4)*_____
Name of provider

_____

to: _____ *c/o* **Ronsin Photocopy, Inc.**
Specify entity and/or agent to receive health information.

_____
Street Address, City, State, Zip Code *Phone Number*

Information to be released, (unless otherwise specified below), is as follows: All Medical Records, Discharge Summary, Laboratory Reports, Emergency Medicine Reports, Billing Statements, Dental Records, History & Physical Exams, Pathology Reports, Operative Reports, Diagnostic Imaging Reports, EKG, Consultations, Progress Notes, Inpatient and Outpatient Records, Radiology (Reports, X-Rays, CT's, MRI's, etc.), photographs, and all records/documents that are stored electronically and applies to records made before, during and after the signing of this form.

☐ Other:_____

Specify date or time period for information to be released:
All records, regardless of date, unless specified: **From:** _____ **To:**_____

Specific Authorizations
The following information is not to be released unless specifically authorized as indicated below:

- ☐ I specifically authorize the release of information pertaining to drug and alcohol abuse diagnosis or treatment.
- ☐ I specifically authorize the release of information pertaining to mental health diagnosis or treatment.
- ☐ I specifically authorize the release of HIV/AIDS testing information.
- ☐ I specifically authorize the release of genetic testing information.

Purpose

This release is for Litigation / Claim purposes unless otherwise specified below:

☐ Continuity of Care or Discharge Planning ☐ Billing and Payment of Bill

☐ At the request of patient / patient representative

☐ Other (state reason)_____

Re-Disclosure & HIPAA Notice

Information disclosed pursuant to this authorization could be re-disclosed by the recipient to someone who is not legally required to keep it confidential and; therefore, it may no longer be protected by state laws or federal confidentiality (HIPAA) laws. However, state law may prohibit the person receiving my health information from making further disclosure of it, unless another authorization for such disclosure is obtained from me, or unless such disclosure is specifically required or permitted by law.

My Rights

I understand this authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for: 1) conducting research-related treatment, 2) obtaining information in connection with eligibility or enrollment in a health plan for 3) determining an entity's obligation to pay a claim, or 4) creating health information to provide to a third party. Under no circumstances am I required to authorize the release of mental health records.

Revocation

I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the individual provider(s) authorized by this document to release my private health information, or the following address:

_____

Street Address, City, State, Zip Code

The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization

A copy of this authorization is as valid as the original.

I am entitled to receive a copy of this authorization.

Expiration of Authorization

Unless otherwise revoked, this authorization expires _____

Insert applicable date or event

If no date is indicated, this authorization will expire 12 months after the date of signing this form.

_____ *Date*:_____

Signature of patient or legal representative

_____ *Time*:_____*a.m. / p.m.*

Printed Name

_____ _____

If signed by someone other than the patient, state your legal relationship to the patient.

Witness or Translator

(1-2011)