

**AUTHORIZATION FOR RELEASE OF  
PROTECTED HEALTH INFORMATION**

I hereby authorize the use and disclosure of my individually identifiable information as described below.

I understand that signing this Authorization is voluntary and that if I refuse to sign this form it will not prevent receipt of health care or eligibility for benefits under my health plan.

I understand that I am entitled to receive a copy of this form upon signing it.

I understand that if the organization or individual authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

I understand that I have a right to revoke this Authorization, but that I must send a written revocation to the person or organization authorized to release my information at the address below. I also understand that the revocation applies only to uses and disclosures made after the revocation is made.

Patient Name: \_\_\_\_\_  
Member Name: \_\_\_\_\_  
Member Social Security Number: \_\_\_\_\_

Person or organization authorized to RELEASE my health information:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

Person or organization authorized to RECEIVE my health information:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

Specific description of information is to be disclosed (be specific, include dates):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What is the purpose of this disclosure? \_\_\_\_\_

This authorization will expire on (date of event): \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_  
Patient

If signed by a patient representative – Representative Name (Print): \_\_\_\_\_

Relationship to Patient, including authority for status as representative \_\_\_\_\_

**This form does NOT authorize the release of psychotherapy notes**

I hereby revoke this authorization: \_\_\_\_\_ Date: \_\_\_\_\_  
Signature