**AUTHORIZATION TO DISCLOSE**

**PROTECTED HEALTH INFORMATION**

**PATIENT INFORMATION**

Patient Name (printed): Previous Name(s):

Date of Birth: Daytime Telephone Number:

**SEND INFORMATION TO: (please be specific)**

Provider Name/Organization:

Address:

City: State: Zip:

Phone #: Fax #:

**INFORMATION TO BE RELEASED FROM: (please be specific)**

Provider Name/Organization:

Address:

City: State: Zip:

Phone #: Fax #:

**PURPOSE OF DISCLOSURE**

Transfer of Care Self Specialist Other (must complete)

**INFORMATION TO BE DISCLOSED**

Medical Records from last two years

Limited Health Information or Documentation Dates of Service:

Complete Medical Chart Contents

Other Expiration Date (or event)

(No more than 90 days forward)

**CONSENT TO DISCLOSE**

If the patient is unable to sign, please indicate such and the authority to act of the person who is signing for the patient. This form must be dated within 90 days of receipt, and may be revoked at any time, providing the information has not already been disclosed. Please see our Notice of Privacy Practices for instructions as to how to revoke this authorization. We will not condition treatment on the completion of the authorization. Also, please be aware that once we disclose this information per your instructions the information is subject to re-disclosure and may no longer be protected by the HIPAA of 1996.

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of patient or representative Relationship to patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DISCLOSURES REQUIRING SPECIAL CONSENT**

My signature below specifically authorizes the release of healthcare information relating to the testing, diagnosis, or treatment for (Please initial beside the specific information to disclose):

HIV/AIDS Virus Mental Health/Psychiatric Disorders

Sexually Transmitted Diseases Drug, Alcohol Abuse/Treatment

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of patient or representative Relationship to patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FOR FACILITY USE ONLY**

Date Received: \_\_\_\_\_\_\_\_\_\_\_ Date Information Released: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Chart #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person/Department Sending Records: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_