Independent Family Doctors

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Name of Patient:_____ Chart #:_____

Date of Birth:_____ SS#:_____

Hereby Authorize:_____ For Release to:_____

Address: _____ Address:_____

City, St., Zip:_____ City, St. Zip:_____

Purpose for this disclosure:

Diagnosis / Treatment Insurance / Billing Personal
Legal Disability Determination Vocational Rehabilitation Evaluation
Other (please specify):_____

Information to be disclosed:	Dates of Service
____Entire Medical Record	_____
____Chart Notes	_____
____Lab - Pathology Reports	_____
____Radiology Reports	_____
____Immunizations	_____
____Other (Please Specify)_____	_____
Verbal Discussion Only – no written release:	_____

Authorization for Disclosure of the Indicated Sensitive Records (requires patient's initials)

____HIV / AIDS Pt's Initials _____ ____Mental Health / Chemical Dependency Pt's Initials _____

I understand that I may revoke this authorization in writing at any time except to the extent action has been taken in reliance on it.
This authorization will remain in effect until:_____(date). If no date is indicated, authorization will remain effective for one year from the signature date unless previously revoked.

I authorize the use and disclosure of my health information described above, including verbal and written unless I indicated otherwise. I understand this authorization is voluntary. I understand that if the person(s) I authorize to receive the information is not a health plan or healthcare provider, the information released my no longer be protected by Federal Privacy Regulations and could be disclosed. I understand that my health care and payment of my health care will not be affected if I do not sign this form.
A photocopy or fax of this authorization will be treated in the same manner as the original.

_____ _____
Signature of Patient/Guardian/Representative Date

_____
(If not Patient, state authority/relationship)