AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, **hereby authorize** _____,
_____,
(address & telephone number)
(the "Practice") to disclose health information regarding the below referenced patient.

Patient Name: _____ **Date of Birth:** _____
Address: _____ **Phone #:** _____
_____
_____

Name of person/organization records to be disclosed to:
_____
_____
_____

This authorization will EXPIRE on _____.

Specific description of information (including date(s)): _____
_____
_____

Purpose of the use or disclosure: ____At the request of the individual ____ Insurance not accepted by MMC ____ Changing Doctor ____ Moving
____ Physician/Staff Request ___ Marketing* ___ Sale of Information* ____ Other :_____
_____

*If the use or disclosure for which authorization is being sought is for marketing purposes, the use or disclosure ([] will [] will not) result in direct or indirect financial remuneration to us from someone else. If we are seeking your authorization to sell your information, the disclosure will result in remuneration to us from someone else.

I understand that I may revoke this authorization at any time by sending a written request to the Practice – Attn: Privacy Officer. However, the revocation will not have any effect on any uses or disclosures the Practice may have made before the revocation was received.

I understand that unless I revoke the authorization earlier, this authorization will automatically expire six (6) months after the date this authorization is signed.

I understand that I may refuse to sign this authorization and that the Practice will not condition treatment on whether or not I sign this authorization.

I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations.

I understand that the information in my health record may include information about behavioral or mental health services, treatment for alcohol and drug abuse, or information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).

I certify that I am (check whichever applies):

___the patient.
___the patient's authorized representative, and that the identification and proof of authority that I have provided are true and correct. My relationship to the patient is that of _____.

Signature: _____ Date: _____

If signature is not that of patient: Print name: _____
Address _____
_____
Phone # _____

**** A COPY OF THIS AUTHORIZATION SHOULD BE RETAINED BY THE PATIENT ****

Date Rcvd: _____
Date Processed: _____
Processed by: _____

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