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AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Authorization for Use/Disclosure of Information: I voluntarily consent to an authorize my health care provider _____ (insert name) to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

Recipient: I authorize my health care information to be released to the following recipient(s):

Name: _____

Address: _____

Phone: _____ Fax: _____

Purpose: I authorize the release of my health information for the following specific purpose: _____.

(Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization)

Information to be disclosed: I authorize the release of the following health information: (check the applicable box below)

All my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.¹

Only the following records or types of health information:

_____.

¹ NOTE: This Authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law, or mental health records that are protected by the Lanterman-Petris-Short Act.

