



Chart # _____

Authorization for Release of Medical Information

I hereby voluntarily authorize the use and/or disclosure of my health information as described below. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations.

This authorization is effective for one year from the date on which it was signed. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to Healthcare Associates of Irving, LLP. I understand that I have the right to inspect the information to be disclosed upon the proper notification to and under conditions established by Healthcare Associates of Irving, LLP.

INSTRUCTIONS: Make sure all blanks are filled in. Failure to do so may prevent or delay release of information.

PATIENT IDENTIFICATION: Name _____ Date of Birth _____

SS # _____ Parents/Previous Name(s) _____

PROVIDER: (Who is releasing the information) Name _____ Address _____

Fax Number _____ Phone Number _____

REQUESTOR: (Where do you want the information sent) Name _____ Address _____

Fax Number _____ Phone Number _____

- INFORMATION REQUESTED: [] Only Records Created By This Office [] Complete Records Retained By This Office [] Lab Data, Date [] EKG, Date [] Progress Notes, Date [] History & Physical, Date [] Immunization Record [] X-ray Data, Date [] X-ray Original Film, Date (Return film within 30 days)

- PURPOSE OF RELEASE: [] At Request of Patient or Legal Representation [] Transferring Medical Care [] Other

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE _____ DATE _____

RELATIONSHIP TO PATIENT, IF NOT SIGNED BY PATIENT _____

I understand my healthcare and payment of my healthcare will not be affected by this authorization.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

PROHIBITION ON REDISCLOSURE

This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements and state requirements prohibit further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.

- I specifically authorize the release of data and information relating to: [] Substance Abuse treatment (Alcohol/Drug) [] Mental health (includes psychological testing) [] HIV-related information (AIDS related testing)

Signature of Patient/Legal Representative _____ Date _____

Relationship to Patient _____

Chart # _____

I specifically authorize the release of data and information relating to: 1. Substance Abuse treatment (Alcohol/Drug)
 2. Mental health (includes psychological testing)
 3. HIV-related information (AIDS related testing)

SIGNATURE OF PATIENT OR
LEGAL REPRESENTATIVE _____ DATE _____

RELATIONSHIP TO PATIENT, IF NOT SIGNED BY THE PATIENT _____