# AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Name:

_____

Health record number: _____

Date of birth: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure:

   _____

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)
   - _____ Enrollment
   - _____ Payment
   - _____ Claims Adjudication
   - _____ Case or medical management records including:
     - _____ Problem(s) [list] from (date) _____ to (date) _____
     - _____ Medication(s) [list] from (date) _____ to (date) _____
     - _____ Most recent history and physical
     - _____ Most recent discharge summary
     - _____ Laboratory results from (date) _____ to (date) _____
     - _____ X-ray and imaging reports from (date) _____ to (date) _____
     - _____ Consultation reports from (doctor's names) _____
   - _____ Enter record from (date) _____ to (date) _____
   - Other

   _____

4. This information may be disclosed to and used by the following individual or organization:

   _____

   Address: _____ for the purpose of: _____

5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to _____. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

_____. If no expiration date, event, or condition is specified, this authorization will expire in six months.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact _____ (insert privacy officer or other office or individual's name or contact information).

**Signature of employee, plan participant, or legal representative**:

_____ **Date**:

_____

**If signed by legal representative, authority to act for employee/plan participate**:

_____

**Signature of witness**:

_____