

HEALTH CARE PROVIDER  
AUTHORIZATION FOR RELEASE OF INFORMATION

**I hereby authorize the use or disclosure of my individually identifiable health information as described below.** I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or a health care provider, the released information may no longer be protected by Federal privacy regulations.

**Name of Patient:** \_\_\_\_\_ **S.S. Number:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Persons/Organizations authorized to disclose the information:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Persons/Organizations authorized to receive the information:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Specific description of information (including date(s)):** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Specific purpose of the user or disclosure:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Expiration date of authorization:** \_\_\_\_\_

I understand that the information used or disclosed may be subject to re-disclosure by the recipient(s) authorized above and may no longer be protected by the Federal privacy regulations. I understand that health care provider will not condition treatment or payment on my signing of this authorization. I understand that I may generally revoke this authorization at any time by notifying the health care provider in writing. However, I may not revoke this authorization to the extent that the health care provider has taken action in reliance upon the authorization. I understand that I will receive a signed copy of this authorization.

I understand my rights and hereby authorize the use or disclosure of my individually identifiable health information as set forth herein.

\_\_\_\_\_  
**Signature of Participant or Personal Representative**

\_\_\_\_\_  
**Date**

**PERSONAL REPRESENTATIVES ONLY**

Printed name of participant's representative: \_\_\_\_\_

Relationship to the participant: \_\_\_\_\_