

**Authorization for Release of Protected Health Information**

I, \_\_\_\_\_ (print patient name) hereby authorize  
\_\_\_\_\_ (“Company”), to disclose the protected health information  
specified below to:

\_\_\_\_\_ Relationship to patient  
Print name of party to receive information

\_\_\_\_\_ Telephone of party to receive information  
Address of party to receive information

I authorize the Company to disclose the following health information to the above specified party:

- Verbal information only informing the above person(s) about details about my medical information without the production of any written records.
- My complete medical records and information including but not limited to, test results, as well as information related to HIV status, drug and alcohol usage, and mental health status (but this Authorization does not include and authorization for the release of psychotherapy notes).
- My medical records for the specific treatment date from \_\_\_\_\_ to \_\_\_\_\_.
- The following specific portions of my medical records and health information:  
\_\_\_\_\_.

1. I authorize Company to use and/or disclose my health information for the following purposes.

- At my request, or
- For the following purposes:  
\_\_\_\_\_

2. This Authorization expires:

- On the following date: \_\_\_\_\_
- When the following event occurs: \_\_\_\_\_

3. I understand that I have the right to revoke this Authorization at any time and that revocation must be delivered in writing to the Company’s administrator. I am aware that my revocation will not be effective if (i) this Authorization was obtained as a condition for obtaining insurance and applicable law permits the insurer to contest the claim or the policy itself; or (ii) to the extent the Company has already acted in reliance upon this Authorization.

4. I understand that I am under no obligation to sign this form and that the Company may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this Authorization.

5. I understand that if the persons I have authorized by this release to obtain my health information are not health care providers, health plans or health care clearinghouses subject to the federal privacy standards, the health information disclosed pursuant to this Authorization may no longer be protected by the federal privacy standards and such persons may be able to re-disclose my health information without obtaining my authorization.

6. I hereby release and agree to indemnify the Company, its parent company, affiliates, employees, officers and directors from any and all liability which in any way results from the disclosure of this information pursuant to the above instructions.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

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**PATIENT'S LEGAL REPRESENTATIVE MUST PROVIDE PROPER DOCUMENTATION**

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The above patient is unable to consent because:

- Minor
- Incompetent
- Other (explain): \_\_\_\_\_

I therefore consent on behalf of the patient named above.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date