

# AUTHORIZATION FOR DISCLOSURE OF PATIENT HEALTH INFORMATION

**I hereby authorize:**

**To Disclose to:**

\_\_\_\_\_  
Name of Disclosing Party

\_\_\_\_\_  
Name of Disclosing Party

\_\_\_\_\_  
Address

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
City State Zip

**records and information pertaining to:**

\_\_\_\_\_  
Name of Member/Patient (List Other Names Used)

\_\_\_\_\_  
Medical Records Number

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone Number

**DURATION:** This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here \_\_\_\_\_ (Date).

**REVOCATION:** This Authorization is also subject to written revocation by the member/patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

**REDISCLASURE:** I understand that the recipient may not lawfully further use or disclose the health Information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

**SPECIFY RECORDS:** Check the box, initial and/or sign to specify which type of information is to be disclosed.

**MEDICAL INFORMATION** \_\_\_\_\_ (INITIAL)

Specify the records to be disclosed: \_\_\_\_\_

The recipient may use the health information authorized on this form for the following purposes:

\_\_\_\_\_  
A copy of this authorization is as valid as the original.  
Member/Patient has a right to the copy of this authorization.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
If Signed by Other than Member/Patient, Indicate Relationship