

# Authorization Form for Release of Confidential Health Information

Patient's Name: \_\_\_\_\_ Address: \_\_\_\_\_

Social Security #: \_\_\_\_\_ DOB: \_\_\_\_\_

Telephone: \_\_\_\_\_

Your Physician is:    \_\_\_ Dr. Friedell    \_\_\_ Dr. Feldstein    \_\_\_ Dr. Wise  
                                 \_\_\_ Dr. Roth            \_\_\_ Dr. Belmonte

I authorize the release of the following information contained in my medical record

- The entire medical record, *excluding* mental health provider, alcoholism, drug abuse, and positive HIV/acquired immune deficiency syndrome (AIDS) treatment records
- Mental Health Provider Records
- Alcoholism Records
- Drug Abuse Records
- Positive HIV/Acquired Immune Deficiency Syndrome (AIDS) Treatment Records
- Laboratory Reports
- X-ray Reports
- Operative Notes
- Other: \_\_\_\_\_

The above information for the following period of time shall be released: From: \_\_\_\_\_ to \_\_\_\_\_.

To: Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State Zip: \_\_\_\_\_

This authorization expires on: \_\_\_\_\_, or in 90 days.

The \_\_\_\_\_ purpose(s) of the \_\_\_\_\_ authorization is \_\_\_\_\_ (are) \_\_\_\_\_ -  
\_\_\_\_\_

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law.

I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.

I understand that this authorization is valid until it expires, unless revoked before that.

I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the physician's office.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

If you are not the patient, please specify your relationship to the patient:  
\_\_\_\_\_.