

**AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION**

Patient's Name: \_\_\_\_\_  
First MI Last

Date of Birth: \_\_\_\_\_ Soc Sec #: \_\_\_\_\_

Authorized Individual/Organizations:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

This request and authorization applies to:  All healthcare information.

Healthcare information relating to the following treatment, condition, or dates: \_\_\_\_\_

Other: \_\_\_\_\_

Definition: I understand that authorizing the disclosure of this health information is voluntary. I can revoke this authorization at any time. To revoke, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the information in my health records may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or HIV. It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date