Name: _____

Call Number: _____

Date of Service: _____

Authorization for Release of Patient Information

I authorize any doctor, hospital, employer, or other person to whom a signed authorization or photocopy of this authorization is delivered to furnish

_____ Itemized bill(s)

_____ Patient Care Report (medical records)

_____ Explanation of benefits (EOB(s))

which may be requested by _____ or its representatives.

I understand that if the person or entity that receives my medical/health information is not a health care provider, healthcare clearinghouse or health plan covered by federal privacy regulations that the information used or disclosed according to this authorization may be re-disclosed by the recipient and may no longer be protected by applicable federal or state privacy laws.

I understand that this authorization will expire within 30 days of issuance.

I understand that according to the state and federal law, I may be charged a reasonable fee by the Releasing Facility for the photocopying of the requested medical/health information.

I understand I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment.

I understand I may revoke this authorization in writing at any time by contacting the Releasing Facility described above, except to the extent the Releasing Facility has taken reliance on this authorization. The Releasing Facility may require that you send your written authorization to a different address than the Releasing Facility's address listed
below.

I understand that protected health information will be released as described herein unless otherwise prohibited.

Authorized Signature _____ Title _____ Date _____