SusanRoss
& ASSOCIATES

Records Release Authorization Form

I, _____ authorize _____

(Client Name) (Healthcare Provider)

to use and disclose the protected health information described below to

_____.

(Individual seeking information)

This authorization for release of information covers the period of healthcare from:

_____ to _____. OR _____ all past, present, and future periods.

I authorize the release of my complete health record with the exception of the following information:

_____Mental health records

_____Communicable diseases (including HIV and AIDS)

_____Alcohol/drug abuse treatment

_____Other (please specify) _____

OR

_____ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

I understand that I have the right to revoke this authorization, in writing, at any time.

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already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

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

_____

Signature of patient or personal representative

_____

Printed name of patient or personal representative and his or her relationship to patien

_____

Date

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