


1. Patient Information

First name _____ Middle name _____ Last name _____
 Patient date of birth / / Previous name(s) _____
MM DD YYYY
 Home address _____
 City _____ State _____ Zip code _____
 Daytime phone _____ Email address (optional) _____
 Medical Record/patient ID number (optional) _____

2. Contact for information about how this form was filled out (optional)

I give permission for the organization(s) listed in section 3 permission to talk to 
 First name _____ Last name _____ about how this form was completed.
 This person can be reached at: Daytime phone _____ Email address (optional) _____

3. I am requesting health information be released from at least one of the following:

Organization(s) name _____
 Specific health care facility or location(s) _____
 Specific health care professional's name(s) _____

4. I am requesting that health information be sent to:

Organization(s) name _____
And/or person: First name _____ Last name _____
 Mailing address _____
 City _____ State _____ Zip code _____
 Phone (optional) _____ Fax (optional) _____
 Information needed by (date) / / (optional)
MM DD YYYY

5. Information to be released

IMPORTANT: indicate only the information that you are authorizing to be released.

Specific dates/years of treatment _____

All health information (*see description in instructions for what is included*)

OR to only release specific portions of your health information, indicate the categories to be released:

| | | |
|---|-------------------|---|
| History/Physical | Mental health | HIV/AIDS testing |
| Laboratory report | Discharge summary | Radiology report |
| Emergency room report | Progress notes | Radiology image(s) |
| Surgical report | Care plan | Photographs, video, digital or other images |
| Medications | Immunizations | Billing records |
| Other information or instructions _____ | | |

The following information requires special consent by law. Even if you indicate **all health information**, you must specifically request the following information in order for it to be released:

Chemical dependency program (*see definition in instructions*)

Psychotherapy notes (*this consent cannot be combined with any other; see instructions*)

6. Health information includes written and oral information

By indicating any of the categories in section 5, you are giving permission for written information to be released and for a person in section 3 to talk to a person in section 4 about your health information.

If you do not want to give your permission for a person in section 3 to talk to a person in section 4 about your health information, indicate that here (check mark or initials) _____

7. Reasons for releasing information

- Patient's request
Review patient's current care
Treatment/continued care
Payment
Insurance application
Legal
Appeal denial of Social Security Disability income or benefits
Marketing purposes (payment or compensation involved? NO YES, amount _____)
Sale (payment or compensation to entity maintaining the information? NO YES)
Other (please explain) _____

8. I understand that by signing this form, I am requesting that the health information specified in Section 5 be sent to the third party named in section 4.

I may stop this consent at any time by writing to the organization(s), facility(ies) and/or professional(s) named in section 3.

If the organization, facility or professional named in section 3 has already released health information based on my consent, my request to stop will not work for that health information.

I understand that when the health information specified in section 5 is sent to the third party named in section 4, the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws.

I understand that if the organization named in section 4 is a health care provider they will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form.

If I choose not to sign this form and the organization named in section 4 is an insurance company, my failure to sign will not impact my treatment; I may not be able to get new or different insurance; and/or I may not be able to get insurance payment for my care.

This consent will end one year from the date the form is signed unless I indicate an earlier date or event here:

Date MM/DD/YYYY Or specific event _____

9. Patient's signature _____ Date MM/DD/YYYY

OR legally authorized representative's signature _____ Date MM/DD/YYYY

Representative's relationship to patient (parent, guardian, etc.) _____

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting genetic information of any individual or family member of the individual, except as specifically allowed by this law.