



Authorization to Release Health Care Information

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Patient's Name: _____ Date of Birth: _____

SSN: _____ Previous Name: _____

My personal health information is private and confidential. I understand that my doctor and his/her staff work very hard to protect my privacy and preserve the confidentiality of my personal health information.

I understand that my doctor and his/her staff may use and disclose my personal health information to help provide health care to me, obtain copies of my medical records from physicians when necessary who have treated me, to handle billing and payment, and to take care of other health care operations. There will be no other uses and disclosures of this information unless I permit it. However, I understand that sometimes the law may require the release of this information without my permission.

I can ask my doctor to limit how my personal health information is used or disclosed to carry out treatment, payment, or health care operations. I understand that my doctor does not have to agree to my request. If my doctor does agree to my request, I understand that my doctor and his/her staff would follow the agreed limits.

I may cancel this consent at any time by doing the following:

Writing, signing, and dating a letter to my doctor directly. If I write a letter, it must say that I want to cancel my consent to authorize the use and disclosure of my personal health information for treatment, payment, and healthcare operations.

If I cancel this consent, my doctor and his/her staff do not have to provide any further health care services to me.

My signature means that I agree to allow my doctor to use and disclose my personal health information to carry out treatment, payment, and healthcare operations.

Patient (or legally authorized individual) signature

Date

Relationship to patient (parent, legal guardian, ect.)