F 3.201(2)F

AUTHORIZATION FORM FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Instructions: All of the Blocks 1-6 must be completed. If any block is not completed then this "Authorization Form" will be considered incomplete and defective and cannot be used.

PLEASE PRINT ALL INFORMATION EXCEPT FOR REQUIRED SIGNATURES.

Block 1: Identification of Patient

PATIENT NAME: _____ DATE OF BIRTH: _____

PATIENT'S ADDRESS: _____

Street[Apt. Number, P.O. Box - as applicable], City, State & Zip Code.

SOCIAL SECURITY NUMBER or OTHER IDENTIFIER: _____

Block 2: Type of Records/Information to be Disclosed: CHECK ONLY ONE OF THE FOLLOWING BOXES (A or B). If neither box is checked or if both boxes are checked then this form will be considered defective and cannot be used. IF YOU WANT BOTH TYPES OF RECORDS DISCLOSED YOU MUST USE TWO SEPERATE FORMS - One for each purpose.

☐ A. Records except for Psychotherapy Notes ☐ B. Psychotherapy Notes only.

DESCRIBE WHAT SPECIFIC RECORDS MAY BE DISCLOSED (examples: All Records, X-Rays only, Records for last 12 months) AND/OR CHECK ALL THAT APPLY:

☐ All Records* ☐ Alcohol/Drug Evaluation or Treatment ☐ HIV/Aids Status

*All includes inpatient/outpatient records, medical, dental, psychiatric, alcohol/chermical/substance abuse, HIV/Aids, pharmaceutical, hospital or physician records, office notes, narrative summaries, telephone messages, correspondence to/from/about me, diagnostic testing results, bills, statements & invoices whether or not you created those records as long as the recores are in your control or possession.

Block 3: Persons, facility, or class of persons who are authorized to disclose (provide) the records/information:

Block 4: Persons, facility, or class of persons who are authorized to receive the records/information:

and his/her/its attorneys, agents, staff, representatives, experts or other designated person by them/it.

Block 5: Expiration: This "Authorization" will expire on _____ (MM/DD/YY) [cannot exceed 1 year from date below] or on the following specific event: _____

Block 6: Authorizing Signature

- This request for disclosure of medical records/information is made at my request for the purpose of legal proceedings.
- I understand that if the person or entity that receives the described records/information is not a health care provider or health plan covered by federal privacy regulations, the records/information may be redisclosed and no longer protected by those regulations.
- I also understand that certain records may be protected by federal or state law and I am requesting that any and all such protected records be released under this authorization.
- I also understand that I may reovke this authorization at any time by delivering/mailing a written revocation to the party or attorney or lawfirm named in Block 4 above.
- If I revoke this authorization it will have no effect on actions already taken on reliance on this form.
- The covered entity will not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the authorization.
- I authorize the disclosure of the records/information described. I have read and understand this form. I am the patient listed or am authorized to act on behalf of the patient and the patient's personal representative. I also permit disclosure of the records upon presentation of a photocopy of this authorization.

_____ _____

Signature of Patient (or Patient's Personal Representative, if applicable) Date of Signature

Personal Representative's Relationship/Capacity to Patient: _____

Printed Name of Personal Representative: _____

Printed Address & Telephone Number of Personal Representative: _____

Revised: October 2002