

Authorization of Disclosure of Health Information

1. I hereby authorize _____ (Facility Name) to disclose the following information from the health records of:

Resident Name _____

Date of Birth _____

To (Recipient) Name _____

Address _____

City _____ State _____ Zip _____

Covering the period(s) of healthcare

Dates:

From _____ to _____

From _____ to _____

2. Information to be disclosed

_____ complete health record

_____ discharge summary

_____ history and physical examination

_____ progress notes

_____ consultation reports

_____ laboratory tests

_____ X-ray reports

_____ other (please specify)

I understand that this information will include information relating to (check if applicable)

_____ Acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection

_____ Behavioral health services/psychiatric care

_____ Treatment for alcohol and/or drug abuse

3. This information is to be disclosed to _____ for the purpose of _____.

4. I understand that authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition. _____

Signed _____

Resident

Date

Legal Representative/Relationship to Resident

Date

Signature of Witness

Date

