# AUTHORIZATION FOR RELEASE OF INFORMATION

## I. Information About the Use or Disclosure

**I hereby authorize the use or disclosure of my individually identifiable health care information as described below.** I understand that this authorization is voluntary and that I may refuse to sign this authorization, and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.

Patient Name: DOB:

Address:

Phone:

ID Number Group Number/Name:

Persons/organizations authorized to receive the information:

Specific description of information to be used or disclosed (including date(s)):

Specific purpose of the disclosure:

This authorization will expire:

## II. Important Information About Your Rights

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation will not have any effect on any actions that the entity took before it received the revocation.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment)
- The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving entity. I have the right to seek assurance from the above-named persons/organizations authorized to receive the information that they will not redisclose the information to any other party without my further authorization.

## III. Signature of Patient or Patient's Representative

Signature of patient or patient's representative:

Date:

Printed name of the patient's personal representative:

Relationship to the patient, including authority for status as representative:

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