

## Authorization For The Use Or Disclosure Of Health Information

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It is important for your doctor to have all of your medical information to ensure that you receive the best care possible. The purpose of sending the health information to your doctor is to assist in identifying any follow-up medical care that may be needed.

Please allow us to send your health information to your doctor by signing the release of information below. We will only send information that pertains to your care.

Member/Individual Name: \_\_\_\_\_  
Member/Individual ID  
or Social Security Number \_\_\_\_\_  
Member/Individual Date of Birth: \_\_\_\_\_

### AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize \_\_\_\_\_ to release my health information to:

Dr. \_\_\_\_\_ [ ] Primary Care Doctor [ ] Therapist  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax \_\_\_\_\_

### INFORMATION TO WHICH THIS AUTHORIZATION APPLIES

- All health information pertaining to any medical history, mental or physical condition, and treatment received.
- Only the following records or types of health information (including any dates):  

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  - I specifically authorize the release of personal health information relating to drug and/or alcohol abuse. The recipient of drug and/or alcohol abuse information disclosed as a result of this Authorization will need my further written authorization to re-disclose this information.

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### NOTICE OF RIGHTS AND OTHER INFORMATION

**Complete your acknowledgement that You understand that:**

- You have the right to review the information that is being used or disclosed;
- You do not have to complete this authorization and your refusal will not affect your benefits unless this authorization is necessary to determine you benefits;
- The information used or disclosed by this authorization may be at risk for re-disclosure by the recipient and no longer protected by federal privacy laws;
- You have a right to revoke this authorization at any time; and
- You have a right to receive a copy of this signed authorization.

**Permission/authorization to release this information expires one year from the date below.**

**Patient Signature:**

\_\_\_\_\_

Date: \_\_\_ / \_\_\_ / \_\_\_\_\_  
pm

Time: \_\_\_\_\_ am /

**Signature:**

\_\_\_\_\_  
*Guardian/Parent/Authorized Representative\*\**

*\*\* Attach a copy of the appropriate legal document granting authority*



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