AUTHORIZATION FOR RELEASE OF INFORMATION

Section A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient name: ___________________________ ID Number: __________

Person(s)/Organization(s) providing the information:
____________________________________________________________________________________________
____________________________________________________________________________________________

Person(s)/Organization(s) receiving the information:
____________________________________________________________________________________________
____________________________________________________________________________________________

Specific description of information (including date(s)):
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

Section B: Must be completed only if a health plan or health care provider has requested the authorization

1. The health plan or health care provider must complete the following:
   a. What is the purpose of the use or disclosure? ________________________________________________
   b. Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes_____ No_____
2. The patient or the patient’s representative must read and initial the following statements:
   a. I understand that my health care and the payment for my health care will not be affected if I do not sign this form. Initials:_________
   b. I understand that I may see and copy the information described on this form if I ask for it, and that I will receive a copy of this form after I sign it. Initials:_________

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Section C: Must be completed for all authorizations

The patient or the patient’s representative must read and initial the following statements:
1. I understand that this authorization will expire on __ __/ __ __/ __ __ __ (DD/MM/YR) Initials:_________
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but that, if I do, the revocation won’t have any affect on any actions the providing organization took before it received the revocation. Initials:_________

______________________________  ______________________
Signature of patient or patient’s representative  Date

(Form MUST be completed before signing)
Printed name of patient’s representative:_____________________________________________________________
Relationship to the patient:_________________________________________________________________________

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION
You may not use this form to release information for treatment or payment except when the information to be released is psychotherapy notes or certain research information.

☐ Refusal to Sign Authorization Form:

______________________________  ______________________
Witness Signature and Date

______________________________  ______________________
Print Witness Name

This form is based on current federal and state law and specifically meets the standard of patient privacy under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), 45 CFR § 164.506.
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