

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Name:

Health record number: _____

Date of birth: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure:

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

_____ Enrollment

_____ Payment

_____ Claims Adjudication

_____ Case or medical management records including:

_____ Problem(s) [list] from (date) _____ to (date) _____

_____ Medication(s) [list] from (date) _____ to (date) _____

_____ Most recent history and physical

_____ Most recent discharge summary

_____ Laboratory results from (date) _____ to (date) _____

_____ X-ray and imaging reports from (date) _____ to (date) _____

_____ Consultation reports from _____ (doctor's names)

_____ Enter record from (date) _____ to (date) _____

Other

4. This information may be disclosed to and used by the following individual or organization:

Address: _____ for the purpose of:

5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to _____. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

