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Authorization to Release Protected Health Information

Patient name:

Last	First	Middle
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Home address:

Home telephone:

Date of birth:

Social security number:

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Specify information to be disclosed: (i.e., medical records, only billing records, only certain dates):

Recipient: (name of person(s) to whom protected health information may be disclosed):

Purpose of use or disclosure: (i.e., personal use, treatment, individual request, etc.):

Term: This authorization shall not expire.

Please mark below if you specifically authorize the release of the following types of protected health information.

Check applicable boxes:

- | | |
|---|---|
| <input type="checkbox"/> Sexually transmitted disease (STD) | <input type="checkbox"/> Behavioral or mental health services |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Alcohol or substance abuse |
| <input type="checkbox"/> Genetic information | <input type="checkbox"/> Child abuse/domestic abuse |

Pursuant to HIPAA Privacy Rules, I/authorized representative acknowledge the right to revoke this authorization at any time. It is understood that revocation of this authorization must be done in writing and presented to the healthcare provider named above; the revocation will not apply to information that has already been released in response to this authorization. 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.

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