AUTHORIZATION FOR RELEASE OF INFORMATION

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

Patient name: _____ Date of birth: _____ SSN: _____

Person(s), class of persons, or organization authorized to use or disclose the information:	Person(s), class of persons, or organization authorized to receive the information:
_____ Name of facility	_____
_____ Street address	_____
_____ City, state and zip code	_____

I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information from the dates _____ through _____, including the following:

- All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical exam, psychiatric/psychological evaluations, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, mental health documentation, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, photographs, videotapes, telephone messages, and records received by other medical providers.
- All physical, occupational and rehab requests, consultations and progress notes.
- All disability, Medicaid or Medicare records including claim forms and record of denial of benefits.
- All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including CT scan, MRI, MRA, EMG, bone scan, myleogram; nerve connection study, echocardiogram and cardiac catheterization results, videos/CDs/films/reels and reports.
- All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.

I understand the information to be released or disclosed may include information relating to STDs, AIDS/HIV, alcohol and drug abuse, and mental health. I authorize the release or disclosure of this type of information. Initials: _____

This protected health information is disclosed for the following purpose: continuity of care

Will the health plan or health care provider receive financial or in-kind compensation in exchange for using or disclosing the health information described above? No (Note: If a health plan or health care provider requests the authorization, it must provide a copy of the signed authorization to the individual.)

I understand that my health care, the payment for my health care, my enrollment in a health plan and my eligibility for benefits under a health plan will not be affected if I do not sign this form, unless (a) the treatment is research-related and the use and/or disclosure is for that research, in which case treatment may be withheld if the authorization is not signed; or (b) the health care to be provided is solely for the purpose of creating health information for disclosure to a third party and the health care provider asks for an authorization to disclose the information to the third party (e.g., a work-related physical), in which case treatment may be withheld if the authorization is not signed; or (c) the authorization is sought by a health plan for its eligibility or enrollment determinations relating to me or for its underwriting or risk rating determinations; provided, however, that the authorization is not for a use or disclosure of psychotherapy notes and that the authorization is requested prior to my enrollment in the health plan, in which case enrollment in the health plan or eligibility for benefits under the plan may be withheld if the authorization is not signed. Initials: _____

I understand that this authorization will expire one year from the date of execution. Initials: _____

I understand that I may revoke this authorization at any time by notifying the facility listed above in writing, but if I do, it won't have any effect on any actions the facility listed above took before it received the revocation. If the authorization was obtained as a condition of obtaining insurance coverage, I understand that my revocation will not affect the insurer's rights to contest a claim under the policy or the policy itself. Initials: _____

Any facsimile, copy or photocopy of this authorization shall authorize you to release the records requested herein. If the requested information cannot be faxed to the jail Attn: Medical under cover sheet, it should be mailed to the jail Attn: Medical at the address above.

_____ _____
Signature of patient or legally authorized representative Date

_____ _____
Printed name and relationship to patient Date

_____ _____
Witness signature Date