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**AUTHORIZATION FOR USE OR DISCLOSURE OF
HEALTH INFORMATION**

Patient's Name

Date of Birth

Account #

Please transfer the records from:

Name

Street Address

City, State, Zip

Phone/Fax Number

RECORDS TO BE TRANSFERRED:

I would like the following transferred:

All the records or

A portion of the records concerning:

(Specify type of disease, accident, dates of treatment, or
other portion of records you are interested in)

This authorization will expire on (enter date of event)
_____ or one year from the date of execution.

I understand that if the recipient of my information is not a
healthcare provider, a health plan or healthcare clearing
house, or not an entity required to comply with federal state
health privacy regulations, my health information may be

further disclosed by such recipient and my information may no longer be protected by state and federal laws.

I have a right to receive a copy of this authorization.

I understand that I may refuse to sign this authorization without affecting my ability to obtain treatment, that I may revoke this authorization at any time in writing as long as it is signed by me or on my behalf, and that my revocation will be effective upon receipt, but would not have an impact on uses or disclosures made while my authorization was valid.

Signed: _____

Date: _____

Printed Name: _____

Telephone: _____

If not signed by patient, please indicate relationship:
