Authorization for Disclosure of Health Information Instructions

Please complete each section:

Section 1.	Regarding Patient/Resident:	▪ Name – last, first, middle ▪ Street Address/P.O. Box ▪ City, State, Zip Code ▪ Telephone Number ▪ Birthdate
Section 2.	Health Information Released To:	▪ Name of individual(s)/Organization ▪ Street Address/P.O. Box ▪ City, State, Zip Code
Section 3.	Providers Use	This section is filled out only by a provider.
Section 4.	I authorize the following facility to disclose the health information identified in Section 4:	▪ Check appropriate box
Section 5.	Specific type of health information to be disclosed	▪ Check appropriate box
Section 6.	Date(s) of health information to be disclosed: Chronic Conditions:	▪ Use this section only if specific dates to be released ▪ Only valid for chronic conditions (i.e. diabetes) that patient authorizes the provider to discuss – VERBAL ONLY
Section 7.	Disclosure may be in the form of:	▪ Check appropriate box
Section 8.	Purpose of need for disclosure:	▪ Check appropriate box

If the requestor is the patient, complete the following:

Section 9.	I understand that this authorization:	▪ Patient to read this section
Section 10.	I understand:	▪ Authorization is valid for 1 year from date signed for only the information requested on this form.
Section 11.	Signature of Patient:	▪ Patient is to sign and date (authorization is not valid without a signature)

If requestor is <u>NOT</u> the patient, but is legally able to sign on behalf of the patient, complete the following:

Section 9.	I understand that this authorization:	▪ Legal Representative to read this section
Section 10.	I understand:	▪ Authorization is valid for 1 year from date signed for only the information requested on this form.
Section 12.	If signed by person other than patient, complete the following: ▪ * For minors: ▪ Signature of person legally authorized:	▪ Check appropriate box ▪ Check appropriate box ▪ Person legally authorized to sign and date (authorization is not valid without a signature)