## Authorization to Release Medical Information

Patient Authorization for Use and Disclosure of Protected Health Information

Patient's Name: _____________________________________________ Date:_______________________________________

*I authorize the use of disclosure of the above named individual's health information as described below.*
*The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)*

The following may be released to:____________________________________________________________________________

Phone:___________________________________Fax:___________________________________________________________

Address:___________________________________________________________________________________________

Medical Information including:_______________________________________________________________

- Current medical condition:_________________________________________________
- Laboratory results from (date)_______________ to (date)_________________________
- Imaging results from (date)__________________ to (date)_________________________
- Consultation reports from (doctor's names) ______________________________________
- Other_______________________________________________________________________

I authorize Harbor View Medical Services, PC to receive the following information from:_______________________________________

Phone:__________________________________ Fax:_____________________________________________________________

Address:___________________________________________________________________________________________

Medical Information including:_______________________________________________________________

- Current medical condition:_________________________________________________
- Laboratory results from (date)_________________ to (date)________________________
- Imaging results from (date)___________________ to (date)________________________
- Consultation reports from (doctor's names) ______________________________________
- Other _______________________________________________________________________

*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 a staff member of Harbor View Medical Services, PC. I understand that the revocation will not apply to information that has already been released by the 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 termination of care.*

*I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I may contact the office manager at the practice.*

X____________________________________________ ____________________________________________

Signature of Patient or Legal Guardian | Date

_____________________________________________ ____________________________________________

Print Name of Patient or Legal Guardian | If not signed by patient, please indicate relationship