Authorization for Disclosure of Confidential Information

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name: _____ *Relationship:* _____

Street Address _____

City _____ State _____ ZIP _____

Email _____ Phone _____

Health Information to be disclosed upon the request of the person named above (Check one):

- ☐ **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognoses, treatment, and billing for all conditions) **OR**
- ☐ **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):

    - ☐ Alcohol/drug abuse treatment
    - ☐ Other (please specify): _____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- ☐ An electronic record or access through an online portal
- ☐ Hard copy
- ☐ Verbal communication

This authorization shall be effective until (check one):

- ☐ All past, present, and future periods, OR
- ☐ Date or event: _____

Unless I revoke it. (NOTE: you may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing)

_____ _____

Name of the Individual Giving this Authorization Date of birth

_____ _____

Signature of the Individual Giving this Authorization Date