

AUTHORIZATION FOR RELEASE OF INFORMATION

Section A: Must be completed for all authorizations

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

Patient name: _____

ID number: _____

Persons/organizations providing the information:

Persons/organizations receiving the information:

Specific description of information (including dates(s)):

Section B: Must be completed only if a health plan or a health care provider has requested the authorization.

1. The health plan or health care provider must complete the following:

a. What is the purpose of the use or disclosure?:

b. Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above?

Yes _____ No _____

