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AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

This Authorization authorizes the release of protected Health Information pursuant to 45 CFR Parts 160 and 164.

1. The undersigned authorizes the release of the following information from and to the parties named.

FROM: ________________________________ TO: ________________________________

(Phone): ______________________________ (Phone): ____________________________

(Fax): ________________________________ (Fax): ______________________________

2. The information may be disclosed by employees or business associates of Provider.

3. The disclosure may be made for the following purpose: ______________________________

4. This authorization will expire on _________________, or after 90 days from the date signed.

5. I acknowledge: (1) that I have the right to revoke the authorization at any time, and (2) that I understand that once the information is disclosed, it may no longer be protected by federal privacy law. This authorization may be revoked only in writing sent by certified mail to the Provider at the address above. The revocation will be effective only upon receipt, except (1) to the extent the Provider has acted in reliance on the authorization, or (2) the authorization was obtained as a condition of obtaining insurance coverage and the insurer wishes to use the protected health information to lawfully contest a claim.

6. I understand that treatment by the Provider is not conditioned on my signing this authorization, although exceptions will be made for (1) research-related treatment, (2) for treatment the purpose of which is creating protected health information for a third party, such as pre-employment physicals, and (3) except for psychotherapy notes, for health plans who condition enrollment or on an authorization request prior to enrollment, or where payment is conditioned on an authorization to us PHI to determine payment.

7. If this authorization is for a marketing use or disclosure of my information, the Provider:

7.1 ____Will be remunerated by a third party.

7.2 ____Will not be remunerated by a third party.

Date: ____________________

Print Name: ________________________________ Signature: ____________________________

Patient's Date of Birth: ____________________

SS#: ______________________________

If the person signing is other than patient, state authority under which signature is made.

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