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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

By signing this Authorization, I hereby authorize _____ to use or disclose certain medical information pertaining to me as set forth below:

1. I authorize the following medical records be used or disclosed:
   - □ Office Notes
   - □ Reports of Surgery, Tests, Procedures: (Please specify) _____
   - □ X-Ray films/ MRI Films
   - □ Other Medical records (Please specify) _____

2. I authorize this information to be used by and disclosed to (name and address): _____ _____.

3. I authorize this information to be used or disclosed for the following purpose:
   - □ To another healthcare provider, at the patient's request.
   - □ To an attorney, at the patient's request.
   - □ At the patient's request, the patient did not supply a reason.
   - □ To a health plan for underwriting, premium rating or related purposes.
   - □ To an insurance company e.g. life, automobile, disability, etc.)
   - □ Other (please specify):

4. I understand that I have the right to revoke this authorization at any time in writing, except to the extent that the **Medical Provider** has already acted in reliance on the Authorization. I can revoke this Authorization by providing a written revocation to the Privacy Officer of the Medical Provider.

5. I understand that the **Medical Provider** may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization.

6. I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer subject to applicable privacy laws.

7. This authorization automatically expires ninety (90) days from the date this authorization was signed.

Authorization from Patient

_____
Signature of the Patient

_____ _____
Printed Name of the Patient Date of Birth

_____ _____
Date Phone no.

Authorization from Person other than Patient

_____
Signature from Person other than Patient

_____
Printed Name of Person other than Patient

_____
Date