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Consent for Release of Confidential Health Information

I, _____ , born _____,
(Name of Patient or Authorized Agent) *(Birthdate)*

residing at _____
(Street Address, City, State and Zip Code)

hereby authorize _____
(*Name of Health Care Facility, Physician, Agency, etc.)*

_____
(Street Address, City, State and Zip Code)

to release to Dr. Greg Cohen the following information contained in my patient record:

☐ The entire medical record, *excluding* mental health treatment, alcoholism treatment, drug abuse treatment, and HIV/acquired immune deficiency syndrome (AIDS) records. *To be disclosed, the following items must specifically be checked:*
- ☐ Mental Health Treatment Records
- ☐ Alcoholism Treatment Records
- ☐ Drug Abuse Treatment Records
- ☐ HIV/Acquired Immune Deficiency Syndrome (AIDS) Treatment Records

☐ Laboratory Reports
☐ X-Ray Reports
☐ Operative Notes
☐ Genetic Testing
☐ Other: _____

The above information shall be released for the following period of time: From: _____ to _____.
(Date) *(Date)*

The purpose(s) of the authorization is (are): _____

_____

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law.

I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.

I understand that this authorization is valid until it expires, unless revoked before that.

I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the physician's office. Absent such written revocation, the Authorization for Release of Confidential Health Information will terminate on _____.
(Date)

Signed: _____ Date: _____

If you are not the patient, please specify your relationship to the patient: _____