# AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient name ______________________________ Date of birth ____________________

I authorize the following healthcare provider to use and disclose my health information described below:

Healthcare provider ______________________________

Mailing address ______________________________

City/State/Zip ______________________________

for the purpose of ______________________________.

The health information to be used and disclosed includes the information specifically authorized below as well as all other information in my health records relevant to the above-described purpose.

_______ By initialing here, I specifically consent to the disclosure of my **HIV/AIDS** information.

_______ By initialing here, I specifically consent to the disclosure of my **mental health** information.

_______ By initialing here, I specifically consent to the disclosure of my **genetic testing** information

_______ By initialing here, I specifically consent to the disclosure of my **drug/alcohol** diagnosis, treatment, or referral information, which requires under federal law a description above of how much and what kind of information is to be disclosed.

**I have reviewed and I understand this authorization. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.**

Patient signature ______________________________ Date ____________________

If Judith King, FNP is requesting this authorization from you for our own use and disclosure, or to allow another health care provider or health plan to disclose information to us:

1. we cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
2. you may inspect a copy of the protected health information to be used or disclosed;
3. you may refuse to sign this authorization; and
4. we must provide you with a copy of the signed authorization.

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this authorization or to the extent you signed this authorization as a condition to insurance coverage. To revoke this authorization, please contact our Privacy Officer. Unless revoked earlier or otherwise, this authorization shall remain in effect for the duration of the patient's tenure.

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