Authorization to Release Protected Health Information

Complete form in its entirety with patient/representative and obtain signature and date or this form is considered invalid.

Patient's Name: _____ DOB: _____

Previous Name: _____ SS #:_____

I request and authorize the following to release my healthcare information:

Attending Physician: _____

Specialty Physician: _____

Hospital (last or where diagnosed): _____

Family/Caregiver: _____
Medical Jewelry Yes No

Please release the information to:

Name of Hospice: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to (check and complete one):

☐ Healthcare information relating to the following treatment, condition: _____

_____

☐ All healthcare information

☐ Other:_____

I authorize the release of information regarding:

☐ Yes ☐ No STD results, HIV/AIDS testing, whether negative or positive
☐ Yes ☐ No Behavioral health service/psychiatric care.
☐ Yes ☐ No Drug, alcohol, or mental health treatment to the person(s) listed above.

I understand I may revoke this authorization at any time by providing written notice.

Patient Signature: _____ Date Signed: _____

Representative Signature: _____ Date Signed: _____