

Authorization for Release of Information

Patient name: _____ Date of birth: _____

Previous name: _____

I. My Authorization

Doctor's Name _____

Address _____

City, State, Zip _____

You may use or disclose the following health care information (check all that apply):

- All health care information in my medical record
 Health care information in my medical record relating to the following treatment or condition:

Health care information in my medical record for the date(s): _____

Other (e.g., X rays, bills), specify date(s): _____

You may use or disclose health care information regarding testing, diagnosis, and treatment of (check all that apply):

- HIV (AIDS Virus) Psychiatric disorders/mental health
 Sexually transmitted diseases Drug and/or alcohol use

You may disclose this health care information to:

Name (or title) and organization: _____

Address: _____ City _____ State _____ Zip _____

Reason(s) for this authorization (check all that apply):

- At my request check only if for marketing purposes
 Other (specify) check only if WWMG will be paid or get something of value for providing health information for marketing purposes

This authorization ends: (This document does not permit disclosure of health information created more than 90 days after the date it is signed.)

in 90 days from the date signed on(date): _____

when the following event occurs: _____

(no longer than 90 days from date signed)

II. My Rights

- I understand I do not have to sign this authorization in order to receive health care.
- I understand I may revoke this authorization in writing at any time.
- I understand that once my health care information is disclosed, the person or organization who receives it may re-disclose it. Privacy laws may no longer protect it.

Patient or legally authorized individual signature

Date

Printed name if signed on behalf of the patient

Relationship