AUTHORIZATION FOR RELEASE OF PRIVATE HEALTH INFORMATION

To: _____

Facility/ Physician where your medical records are located.

_____

Address

_____

City State Zip

_____

Phone Fax

I hereby request that my Private Health Information be Released to:

_____

Facility/Physician

_____

Address

_____

City State Zip

Specific information to be released to the above referenced entity:

_____

_____

_____

This Authorization shall be deemed to expire on the earlier of one (1) year from the date set forth next to my signature or within reasonable time following completion of the event which gave rise to the purpose of this Authorization.

I understand that I have the right to revoke this Authorization in writing at any time and that I may do so by delivering a revocation in writing to the Clinic.

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the receiving entity and may no longer be protected by the Privacy Standards of this Clinic.

The Clinic has informed me that the Clinic will not condition treatment, payment, enrollment, or eligibility for benefits on obtaining this authorization.

I understand that I may refuse to sign this Authorization.

Patient name (print):_____ **D.O.B**._____

Signature:_____**Date**:_____

In the event the Authorization is being executed by a personal representative, guardian, or parent, please print your name and relationship to the patient._____

_____

mana medical associates

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