Authorization for Release of Protected Health Information

Patient Name: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Date of Birth: _____ Telephone: _____

I hereby authorize and consent to disclosure of health records as stated below. I am aware that the records disclosed might be records whose confidentiality is protected by either Federal Regulations (42 C.R.F., Part 2) or State Regulations (I.C. 16-39-16). The records may include alcohol and/or substance abuse and mental health documentation as well as HIV results.

1. Information to be disclosed (dates of service): _____
   - □ Office Visit/Progress Notes
   - □ Laboratory Reports
   - □ Radiology Reports (x-ray, CT, MRI, etc.)
   - □ EKG/Cardiac Testing
   - □ Other: _____
   - □ I authorize the release of information protected by Federal and State Regulations including alcohol/substance abuse, mental health documentation, and HIV results.

   Signature: _____

2. I authorize _____
   to release information to _____

3. I authorize _____
   to obtain information from _____

4. The purpose or need for this disclosure is _____

5. This authorization is valid for as long as reasonably necessary to fulfill the purpose for which it is given. **This will not exceed 60 days.**

6. This authorization may be revoked at any time, except to the extent that action has already been taken.

7. Information to be released in the following manner:

   □ Verbally
   □ Photocopy
   □ Faxed (_____)

Signature of Patient _____Date _____