APPENDIX A
AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Name of Patient _____ Birth Date _____

Street Address _____ City, State, Zip Code _____

I hereby authorize:

Name _____

Street Address _____

City, State, Zip Code _____

To disclose my protected health Information, as described below, to:

Name of Individual or Entity _____

Street Address _____

City, State, Zip Code _____

Information to be released:

___ Medical History, Examination Reports
___ Laboratory Reports
___ Sexually Transmitted Disease
___ Hospital Records Including Reports
___ Allergy Records
___ Dental Records
___ Other _____

___ Treatment or Tests
___ HIV Test Results*
___ Surgical Reports
___ Developmental Disabilities
___ Drug Abuse
___ Radiographs

___ X-Ray Reports
___ Mental Health
___ Prescriptions
___ Consultations
___ Alcoholism
___ Oral/Facial Images

*A listing of the statutory exceptions to release of HIV test results without consent is available.

Purpose for Need of Disclosure

_____

_____

_____ At the request of the individual

I understand that the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information might be redisclosed without my authorization.

I understand that I have the right to:

- **Receive a Copy of This Authorization.**
- **Refuse to Sign This Authorization** and that treatment, payment, enrollment in a health plan or eligibility for health care benefits may not be contingent on my signing this authorization.
- **Revoke This Authorization**, except to the extent that the person(s) and or organization(s) listed above have already made in reference to this authorization.

This authorization will remain in effect until the following date(s): _____, or event: _____

Signature of Patient (or Legal Representative) _____ **Date** _____

Relationship to Patient _____ **Date** _____