

**Mahube-Otwa Family Health  
AUTHORIZATION FORM FOR RELEASE OF INFORMATION**

<b>Patient Name:</b>	Last	First	MI	Maiden/Other Name	Patient #:
<b>Date of Birth:</b> Mo/Day/Year	<b>Day Phone:</b> (Contact OK Y / N)		<b>Evening Phone:</b> (Contact OK Y / N)		

**1. Authorization:**

**I authorize**

Name: (person or clinic)	
Address:City/State/Zip	
Phone:	
Fax:	

**to use and disclose the protected health information described below to:**

Name: (person or clinic)	
Address:City/State/Zip	
Phone:	
Fax:	

**2. Effective Period**

This authorization for release of information covers the period of healthcare from:

- \_\_\_\_\_ to \_\_\_\_\_  
or  
 all past, present, and future periods

**3. Extent of authorization**

- I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).  
 I authorize the release of my complete health record with the exception of the following information:
- Mental health records
  - Communicable diseases (including HIV and AIDS)
  - Alcohol/drug abuse treatments
  - Other (please specify): \_\_\_\_\_

**CONDITIONS OF AUTHORIZATION**

1. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposed as I may direct.
2. This authorization shall be in force and effect until \_\_\_\_\_ (date or event), at which time this authorization expires.
3. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
4. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
5. Mahube-Otwa Family Health will not penalize me if I do not sign this authorization.
6. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
7. I have been offered a copy of this signed authorization form.

\_\_\_\_\_ **Date:** \_\_\_\_\_  
**Patient Signature or personal representative**

\_\_\_\_\_ **Date:** \_\_\_\_\_  
**Printed name of patient or personal representative and his/her relationship to patient**

\_\_\_\_\_ **Date:** \_\_\_\_\_  
**Staff Signature**

Patient Identity confirmed by (Picture I.D./Signature/SS#): \_\_\_\_\_