

## AUTHORIZATION FOR RELEASE OF INFORMATION

\_\_\_\_\_  
(Name of Patient) (Date of Birth) Daytime Phone

\_\_\_\_\_  
(Address) (City) (State) (Zip)

Dates of Treatment or Service: \_\_\_\_\_

I authorize Dr. \_\_\_\_\_, Clark Physician Group, to  
**DISCLOSE** information specified below to:

I authorize Dr. \_\_\_\_\_, Clark Physician Group, to  
**OBTAIN** information from:

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

City/State: \_\_\_\_\_

City/State: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Fax: \_\_\_\_\_

**Information to be Disclosed**

- |   |   |
|---|---|
| <input type="checkbox"/> Diagnosis/Dates of Treatment<br><input type="checkbox"/> Discharge Summary (includes diagnosis, history, results of treatment, prognosis)<br><input type="checkbox"/> History and Physical<br><input type="checkbox"/> Emergency Room Records<br><input type="checkbox"/> Entire Record<br><input type="checkbox"/> Consultation<br><input type="checkbox"/> Other, explain: _____ | <input type="checkbox"/> Operative Report<br><input type="checkbox"/> HIV (AIDS or AIDS related information)<br><input type="checkbox"/> Lab Results (Specified Date or All) _____<br><input type="checkbox"/> (X-rays, EEG, EKG, etc.)<br><input type="checkbox"/> Psychological/Psychiatric Evaluation<br><input type="checkbox"/> Pathology<br><input type="checkbox"/> Letter confirming attendance/treatment |
|---|---|

**Purpose or Need For the Disclosure:**  Physician / Hospital - Continuity of Care  Personal Use  Legal  Disability

Other, Explain: \_\_\_\_\_

I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: \_\_\_\_\_. If I fail an expiration date, event or condition, this authorization will expire in 60 days.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization.

I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I understand that if I have been treated for drug or Alcohol abuse my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

Date: \_\_\_\_\_  
\*Signature of Patient or Legal Guardian

Witness: \_\_\_\_\_ Relationship to Patient

CPG has permission to fax my Health Information to: \_\_\_\_\_ Fax #

ID Verification No.: \_\_\_\_\_ Copied By: \_\_\_\_\_

Date Released: \_\_\_\_\_

