

Authorization to Release Protected Health Information

I hereby authorize the use or disclosure of my protected health information as described below. I understand this authorization is voluntary. I understand the medical records released may contain protected health information concerning HIV/AIDS diagnosis or treatment.

Patient's Full Name:	
Patient's Previous Name:	
DOB:	SS#:
Address:	City, State, Zip:
Person/Organization Requesting Information:	
Person/Organization <u>Providing</u> Information:	
Requested dates of Protected Health Information:	to
Description of Requested Health Information:	
Reason for Disclosure:	
I understand that I may revoke this authorization person/organization, in writing, that I am revoking affect actions taken by the requesting person/org written request to revoke I understand that this authorization will ex	ng this authorization. Such actions will not anization prior to the date they receive you this authorization.
Signature of Patient or Patient's Authorized Representat	ive Date
Authorized Representative's Relationship to Patient	Date
Witness	