

Authorization for release of information



Patient name: _____ (Last, First, MI) Date of Birth: _____

I hereby authorize:

(Name and contact information of sending party)

To release information to:

(Name of recipient and mailing address, email address, and fax number)

Purpose of disclosure:

- | | | |
|--|--|---|
| ☐ Medical treatment/continuing care | ☐ Legal | ☐ Personal use |
| ☐ Billing or insurance | ☐ Determination of disability | ☐ Other (specify): _____ |
| ☐ School | | |

Information to be released:

- ☐ Specific dates of treatment: from _____ to _____
- ☐ All health information

OR the following checked categories:

- | | | |
|---|--|---|
| ☐ Discharge summary | ☐ X-ray reports | ☐ Orders |
| ☐ HP exam/initial evaluation | ☐ X-ray films/MRI | ☐ Outside provider records |
| ☐ Consultation reports | ☐ Diagnostic test reports | ☐ Past/present medications |
| ☐ Biometric screening data | ☐ Procedure reports | ☐ Correspondence |
| ☐ Progress/provider notes | ☐ Lab reports/pathology | ☐ Billing |
| ☐ Other: _____ | | |

Your initials are required to release the following information:

_____ Mental health records	_____ Drug, alcohol, or substance abuse records	_____ Genetic information
_____ HIV/AIDS test results/treatment		

Acknowledgement of understanding:

- I understand the expiration date of this authorization is _____ or 1 year from today's date, whichever is sooner.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance on it.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
- I understand this consent for release of alcohol and/or drug abuse information is subject to revocation at any time except to the extent that the program or person, which is to make the disclosure, has already acted in reliance on it.
- I understand Marathon Health may not condition my treatment, payment, enrollment or eligibility for benefits on my signing this authorization.
- I understand I am entitled to receive a copy of this form after I have signed it.
- I understand a photocopy or fax of this form is the same as the original.

Signature of participant or representative

Today's Date

Relationship to patient (circle one): Self Parent Legal guardian Other: _____