Howard Brown Health

AUTHORIZATION FOR RELEASE OF INFORMATION

Name:_____ Date of Birth:_____ SSN:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Email (optional):_____

I hereby authorize and request that Howard Brown Health release information as follows (check as applicable)**:**

_____**To me** _____**To the following:** _____

_____

City:_____ State:_____Zip:_____

Phone:_____ Fax:_____

Conditions or limits on disclosure (optional):_____

I request the release of the following information (INITIAL ALL THAT APPLY):*

_____COMPLETE HEALTH RECORD	_____X-rays	_____Lab Tests/Reports
_____Discharge Summary	_____Radiology	_____Case Management Notes/Reports
_____History and Physical Exams	_____EKG/EEG	_____ **COVID test results/employer letters**
_____Physician/Consultation Reports	_____Progress Notes	_____ Other:_____

The release of information on certain conditions/treatments requires my specific authorization. WITHOUT THIS AUTHORIZATION, THIS INFORMATION WILL NOT BE RELEASED. I authorize the release of information relating to the following (INITIAL ALL THAT APPLY):

_____Mental/Behavioral Health	_____Sexually Transmitted Diseases
_____Developmental Disability	_____HIV/AIDS
_____Alcohol/Substance Abuse	_____DNA Testing/Genetic Disorders
_____Domestic Violence/Sexual Assault	_____ANY AND ALL OF THE ABOVE-LISTED CONDITIONS/TREATMENTS

Purpose of disclosure:_____ Date/range of requested information (if applicable):_____

FOR EMAIL OR VOICEMAIL/ANSWERING MACHINE DELIVERY OF INFORMATION:

If authorizing email delivery (to you only), you must initial the following: _____ (initial) I hereby authorize that the information requested above may be delivered to me via secure, encrypted email to the email address listed above. I understand that Howard Brown Health cannot guarantee the privacy or security of my email address or device. I understand these risks and consent to and authorize the delivery.

If authorizing voicemail/answering machine delivery (to you only), you must initial the following: _____ (initial) I hereby authorize that the information requested above may be delivered to me via voicemail or answering machine at the phone number listed above. I understand that Howard Brown Health cannot guarantee the privacy or security of my voice-mail or device. I understand these risks and consent to and authorize the delivery.

This Authorization is valid for one year or until (select date no more than 12 months from signature):_____

I UNDERSTAND THAT THIS AUTHORIZATON IS VOLUNTARY, AND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY WRITING TO THE ADDRESS ABOVE. ANY REVOCATION DOES NOT APPLY TO RECORDS ALREADY RELEASED IN GOOD FAITH PURSUANT TO THE ABOVE RELEASE. I UNDERSTAND THAT WHEN INFORMATION IS USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION, IT MAY BE SUBJECT TO RE-DISCLOSURE BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED HEALTH INFORMATION. I UNDERSTAND THAT I HAVE THE RIGHT TO INSPECT AND COPY THE INFORMATION BEING DISCLOSED PURSUANT TO THIS AUTHORIZATION. I UNDERSTAND THAT A MEDICAL PROVIDER TO WHOM THIS AUTHORIZATION IS FURNISHED MAY NOT CONDITION ITS TREATMENT OF ME ON WHETHER OR NOT I SIGN THE AUTHORIZATION, BUT IT HAS BEEN EXPLAINED TO ME THAT IF I DECLINE TO CONSENT TO THIS RELEASE OF INFORMATION, THE FOLLOWING CONSEQUENCES MAY APPLY, AS RELEVANT: MY PROVIDERS MAY BE UNABLE TO COORDINATE MY CARE; I MAY BE UNABLE TO APPLY FOR THIS PROGRAM; AND/OR THE REQUESTED RECORDS MAY NOT BE RELEASED. ANY COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORIGINAL.

_____ _____ _____ _____

Signature of Person Authorizing Release | Date | Signature of Witness (Optional) | Date

NOTE: This Authorization must be completed in its entirety in order to be valid. If the authorization signature is from a person other than the person receiving care, indicate the basis of the authorization and consent:_____

*** Requests for records may incur a charge, if and as allowed by law.**

Rev. 11/2020