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REQUEST FOR AND CONSENT TO RELEASE OF INFORMATION FROM INDIVIDUAL'S RECORDS

BACKGROUND INFORMATION

NOTE: The execution of this form does not authorize the release of information other than that specifically described below. This form authorizes the release of information that you specify in accordance with 5 U.S.C., Section 5701 and 7332; and 45 C.F.R., parts 160 and 164.

Individual/Patient Last Name _____ Individual/Patient First Name _____ MI _____ Date of Birth (MM / DD / YYYY) _____ / _____ / _____

Individual or Organization's Name to Whom Information is Being Released _____ Fax _____

Address _____ City _____ State _____ Zip _____

Information Requested:

Purpose(s) or need for which information is to be used by Organization of Individual to whom information is to be released:

AUTHORIZATION AND CERTIFICATION

I certify that this request has been made freely, voluntarily, and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand this release may not be obtained or offered as condition for treatment, payment, or other eligibility for benefits upon my signing this authorization. I may revoke this authorization at any time in writing, except to the extent that this action has already been taken to comply with it. Written revocation is effective upon receipt by the facility housing the records. Upon release, my records will no longer be protected, and re-disclosure by those receiving the information may be accomplished without my further authorization. Without my express revocation, the authorization will automatically expire upon satisfaction of the need for disclosure, under the conditions listed below, or upon this date _____ (supplied by individual/patient).

Individual/Patient Signature _____ Date (MM / DD / YYYY) _____ / _____ / _____

Personal Representative Signature, if not signed by patient* _____ Date (MM / DD / YYYY) _____ / _____ / _____

*[NOTE: ATTACH DOCUMENTS DEMONSTRATING YOUR AUTHORITY TO ACT ON BEHALF OF THE PATIENT.]
PLEASE FAX COMPLETED FORM TO: 713.798.2787

OP.FR 6 Authorization For Release of Protected Health Information