AUTHORIZATION TO RELEASE
PROTECTED HEALTH INFORMATION

To: Any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment, or services to me or on my behalf, and any other individual, person, entity, or plan that is a covered entity, as defined in 45 C.F.R. § 160.103, with respect to me, or a business associate of any such covered entity, as defined in 45 C.F.R. § 160.103, (hereafter, collectively, "Covered Entities").

From: _____ _____
Name Address

1. Authorized recipients.
By signing this authorization form, I understand I am giving my authorization to each Covered Entity described above to disclose my Protected Health Information to the following individuals, persons, or entities:

a. All primary and successor agents under my Health Care Power of Attorney;

b. Any acting Trustee of my Grantor Trust, formally named as follows:

_____

_____

c. Other: _____

_____

_____

_____

2. This authorization shall not apply to the following:

a. **Psychotherapy notes**. The term "psychotherapy notes" means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes exclude medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of (1) diagnosis, (2) functional status, (3) the treatment plan, (4) symptoms, (5) prognosis, and (6) progress to date.)

b. **Research studies**.

3. No conditioning of treatment.
I understand that no Covered Entity may condition my medical treatment on whether or not I sign this authorization.

4. Protected Health Information Authorized.
I specifically authorize each and all Covered Entities to disclose the following Protected Health Information (delete any of the following for which disclosure is not authorized by striking through with a pen):

A. Any medical records or reports;
B. X-rays or other radiological films or test results or reports;
C. Photographs, films, videos or slides;
D. Emergency Records;
E. Hospital/Inpatient records;
F. Clinic/Outpatient records;
G. Laboratory and pathology reports;
H. Pharmacy reports and records of prescriptions;
I. Any other information relating to my medical history, diagnosis or prognosis;
J. Itemized statements, charges or bills; and
K. Any records pertaining to drug, alcohol, psychiatric, HIV/AIDS testing and/or treatment.

In addition to those items not struck out in Sections 5(a) – (k), I authorize each and all Covered Entities to disclose the following protected health information to the individuals, persons, or entities specified in Section 1 above: _____

5. Purpose of Release of Protected Health Information.
Protected Health Information may be disclosed to the individuals, persons, or entities described in Section 1 above for the following purposes:
(If you would like information disclosed to Authorized Recipients upon request, write "Upon Request" below.)

_____

6. Revocation.
I may revoke this authorization for any Covered Entity at any time by notifying such Covered Entity in writing. Such revocation will be effective for a Covered Entity only when received by the Covered Entity. I understand that any such revocation will not have any effect on any information already used or disclosed prior to the time the Covered Entity receives my written notice of revocation.

7. Expiration.
This authorization will expire _____ days from the date of this Authorization. (*Leave this blank if you want this Authorization to continue until revoked in accordance with paragraph 6 above.*)

8. Re-disclosure of Protected Health Information.
I understand that if the individuals, persons, or entities authorized to receive Protected Health Information in Section 1 above, are not a health plan or health care provider, the released information may no longer be protected by federal or state privacy regulations and may be re-disclosed by the recipient.

9. Right to Inspect and Receive a Copy of Protected Health Information.
I understand I may inspect and receive a copy of the information obtained using this authorization.

10. Voluntary Authorization.
This authorization is voluntary and I may refuse to sign this authorization form. I understand I am not required to sign this authorization in exchange for receiving medical treatment from any Covered Entity.

11. Validity of Electronic Copies.
A photo static copy of this Authorization or a copy transmitted by telecopy or facsimile machine shall be considered as valid as the original.

This Authorization to Release Protected Health Information is executed by my hand on _____, 20__.

_____

This document prepared by: