Authorization to Disclose Health or Billing Information

PATIENT INFORMATION Medical Record #	Date of Birth
Patient Name	Patient Address
Patient Nickname/Maiden Name	

I give permission to:	**To release information to:**
Name of Person/Facility	Name of Person/Facility Address
City/State/Zip	City/State/Zip
Phone # Fax #	Phone # Fax #

Check information to release

❑ Name	❑ History & Physical	❑ Nurses Notes
❑ Address	❑ Laboratory Report	❑ Operative Report
❑ Phone Number	❑ Radiology Report	❑ Medication Records
❑ Insurance	❑ Radiology Images	❑ Progress Notes
❑ Social Security #	❑ Consultation	❑ Discharge Summary
❑ Entire Medical Record	❑ Other (Describe)_____	

Treatment Dates (If certain dates are wanted)

This is a full release including all drug, alcohol, psychiatric and sexually transmitted disease information unless listed here:

_____

Check reason for release ❑ Patient Request ❑ Workers' Compensation ❑ Disability ❑ Treatment ❑ Insurance ❑ Other (Describe)

Release Information ❑ In Person ❑ Pick up ❑ Fax ❑ Mail ❑ Other (Describe)

1. By law, Batish Family Medicine can't use or share my health information without my permission except by ways listed in Batish Family Medicine's notice of Privacy Policies.
2. I can cancel this authorization at any time. I must cancel in writing and address it to the person or organization named above. I can't cancel consent for information already shared as a result of this permission.
3. I don't have to sign this form. Refusal won't change my ability to get treatment, payment for treatment or benefits.
4. Once information is sent, it may not be protected by law and someone may be able to share my information with others without my permission.
5. I have read, understand and been given a copy of this form.
6. This is not for use for Marketing or Research.

NOTICE: I may be charged to copy or mail this information.

Authorization expires 90 days after I sign it unless a date or event is written here:_____

_____

_____

Patient/Patient Representative Signature Date

Legal Authority to sign for patient: ❑ Guardian ❑ Administrator/Executor ❑ Attorney in Fact ❑ Parent ❑ Next of Kin

❑ Other (Specify) _____

Patient is ❑ Minor ❑ Disabled ❑ Deceased ❑ Incompetent ❑ Incapacitated

If limited English proficient or hearing impaired, offer interpreter at no extra cost:

Interpreter: ❑ Accepted ❑ Refused _____

(Name/Number of Person/Services Chosen/Used)