

# **AUTHORIZATION TO OBTAIN OR RELEASE HEALTH INFORMATION**

##### **Complete All Sections, Sign and Date**

##### I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth MM/DD/YYYY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date range of records From: MM/DD/YYYY\_\_\_\_\_\_\_\_\_\_\_\_\_ To: MM/DD/YYYY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##### Expiration Date (1 year expiration)

This authorization will expire on MM/DD/YYYY \_\_\_\_\_\_\_ \_\_\_\_\_\_

##### OR on the occurrence of the following event \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person/organization that health information will be transferred from: Rehabilitation Partners

Person or organization using or receiving the information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorization may be revoked at any time by notifying Privacy Officer, Rehab Partners, in writing at P.O. Box 95590 Albuquerque, NM 87199. If I revoke this authorization, I understand that it will not have any effect on actions Rehab Partners took before it received the revocation. I understand that Rehab Partners will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

Signature of patient or patient’s representative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date MM/DD/YYYY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name of patient’s representative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient\_\_\_\_\_\_\_\_\_\_\_\_

Witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date MM/DD/YYYY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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