# Authorization to Release Medical Information and Records

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I hereby request and authorize **North Coast Family Health** to release any and all health information regarding treatment rendered to me, and to discuss any information or opinions regarding the same, to:

**Provider's Name** _____
*(Physician, Hospital, etc.)*

**Address** _____

**Phone/Fax** _____

Other information to be disclosed: _____

Information that I refuse to disclose: _____

The purpose of this release is to: _____

I understand that my medical record contains information relating to my diagnosis and treatment and I authorize the release of all such information listed above, except those items I have specified. I understand that I may review my records and refuse authorization to disclose all or some of the above health care information. I further understand that I may revoke this authorization by written notice to the health care provider at any time, except where the health care provider has already acted upon the authorization. I further understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient. This authorization is valid for a period of 30 months from the date of signing, unless an earlier date is assigned: _____.

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If I have been diagnosed or treated for any of the following, I understand that my health care provider(s) need my specific consent to disclose related information.

1. **SUBSTANCE ABUSE RECORDS**
   I (_____ Do / _____ Do Not) authorize disclosure of information that refers to treatment or diagnosis of drug or alcohol abuse. Such information may no be disclosed by the recipient without my specific written consent.

2. **MENTAL HEALTH RECORDS**
   a. I (_____ Do / _____ Do Not) authorize disclosure of information that refers to treatment or diagnosis of mental health. Such information may not be re-disclosed by the recipient without my specific written consent.
   b. I (_____ Do / _____ Do Not) want to review such information before it is released. I understand that review must be supervised.

3. **HIV RECORDS**
   I (_____ Do / _____ Do Not) authorize disclosure of information that refers to HIV test results, infection status, or treatment information. Such information may not be re-disclosed by the recipient without my specific written consent.

I understand that I am entitled to a copy of this authorization. A photocopy of this authorization shall be considered as effective and valid as the original.

By: _____ Date: _____

Patient: _____ SS# _____
*(Print or type name)*

By: _____ Date: _____
*Authorized Representative, (if applicable)*

Authorized Representative: _____ Relationship _____
*(Print or type name)*