AUTHORIZATION FORM FOR RELEASE OF CONFIDENTIAL HEALTH INFORMATION (HIPAA COMPLIANT)

I, ___________________________________, hereby authorize ______________________________________
(Patient Name) (Facility/Physician Name)

to release to: ____
(Name of Health Care Facility, Physician, Agency, etc.)

____
(Street Address, City, State, Zip code and Phone Number)

the patient record of: ______________________________________ ________________
(Patient Name) (Date of Birth)

____
(Street Address)

_____________________________ ________ ______________
(City) (State) (Zip Code)

The purpose of the authorization is/are ____

____

Information to be released:

- □ The most recent 2 years of pertinent information (chart notes, labs, x-rays, and special tests)
- □ All medical records
- □ Specific information (Please specify)____

I understand that my records may contain certain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted disease, drug and/or alcohol abuse, mental illness, or psychiatric treatment. My specific authorization for these records to be released is indicated below.

INCLUDE the following information in the records released (please sign full name):

_________________________________ Drug/Alcohol abuse treatment and diagnosis
_________________________________ HIV/AIDS diagnosis/treatment/testing
_________________________________ Sexually Transmitted Disease
_________________________________ Mental Illness or psychiatric diagnosis/treatment

I understand that I may revoke this authorization at any time by giving written notice to the physician if I desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the physician's office. Absent such written revocation, this Authorization of Release of Confidential Health Information will terminate 90 days after the date below.

Signature of patient/guardian: ______________________________________ Date:_______________

If you are not the patient, please specify your relationship to patient:_______________________________

Records releases can be emailed to records@jacksonvision.com or mailed to PO Box 3840, Carbondale, IL 62902