RELEASE OF INFORMATION FORM

Patient Name:		Date of Birth (MM/DD/YYYY)	
Street Address:	City:	State:	Zip Code:
Daytime Phone (with area code):	Cell Phone (with area code):	Message Phone (with area code)	

My information can be released to the following individuals/organizations:

My Primary Care doctor (enter first and last name)	My Specialist (enter first and last name and specialty)
My Obstetrician (enter first and last name)	My insurance company (name)
My Specialist (enter first and last name and specialty)	Other:

I allow the following information to be used or released on my behalf:
Check only one box

- ☐ All my information. This can include health, diagnosis, claims, doctors and other health care providers and financial information (billing and banking). This does not include sensitive information unless it is approved below.
  OR
- ☐ Only limited information may be released (check all boxes that apply)
  - ☐ Benefits and Coverage
  - ☐ Billing
  - ☐ Claims and payment
  - ☐ Diagnosis
  - ☐ Doctor and hospital
  - ☐ Eligibility & enrollment
  - ☐ Financial
  - ☐ Medical records
  - ☐ Pre-certification and pre-authorization (for treatment approvals)
  - ☐ Referral
  - ☐ Treatment
  - ☐ Dental
  - ☐ Vision
  - ☐ Pharmacy
  - ☐ Other:_____

I also approve the release of the following types of sensitive information:

- ☐ All sensitive information
  OR
- ☐ Just information about topics checked below:
  - ☐ Abortion
  - ☐ Abuse (sexual/physical/mental)
  - ☐ Substance Use Disorder [1,2]
  - ☐ Genetic Testing
  - ☐ HIV or AIDS
  - ☐ Maternity
  - ☐ Mental Health
  - ☐ Sexually transmitted illness
  - ☐ Other: _____

[1] Specify time period of records to be disclosed: _____
Description of records that may be disclosed: _____

[2] I understand that my substance use and/or Mental Health records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I also understand that I may revoke/cancel this approval at any time.