CALDERA
family medicine

Authorization for Disclosure of Protected Health Information

Last Name:	First:	MI:	Date of birth:
Other Names used:	Patient address:		Phone:

By signing this form, I authorize the following record holder to disclose confidential information about me

Releasing records from:		Specific information to be disclosed:	Mutual exchange: YES/NO
Street Address:			
City:	State:		
Phone:	Fax:		

If the information contains any of the types of records or information listed below, additional laws relating to use and disclosure may apply. I understand that this information will not be disclosed unless I place my initials in the space next to the information.

HIV/AIDS:	Mental Health:	Genetic Testing:	Drug/Alcohol Treatment:

Releasing records to:		Purpose for disclosure:	Mutual exchange: YES/NO
Street Address:			
City:	State:		
Phone:	Fax:		

***This Authorization is valid for one year from the date of signing unless otherwise specified.** *I can cancel this authorization at any time. The cancellation will not affect any information about my care. I understand that state and federal law protect information about my care. I understand what this agreement means, and I approve of the disclosures listed. I am signing this authorization of my own free will.*

Signature (patient or representative):	Relationship to patient:	Date:
Signature of witness:	Printed witness name:	Date:
Signature of sending staff:	Printed staff name:	Fax/Mail date: