



AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____
Last First MI Date of Birth

I hereby authorize:
(Name and contact information of sending party)

To Release Information to:
(Name of recipient and contact information)

Name: _____
Mailing Address/Fax Number/Email Address: _____

Purpose of Disclosure:

- Medical treatment/Continuing Care
- School
- Determination of Disability
- Other (specify): _____
- Billing or Insurance
- Legal
- Personal Use

Information To Be Released:

- Specific dates of treatment: from _____ to _____
- All Health Information

OR the following checked categories:

- | | | |
|---|--|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> X-Ray Reports | <input type="checkbox"/> Orders |
| <input type="checkbox"/> HP Exam/Initial Evaluation | <input type="checkbox"/> X-Ray Films/MRI | <input type="checkbox"/> Outside Provider Records |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Diagnostic Test Reports | <input type="checkbox"/> Past/present medications |
| <input type="checkbox"/> Biometric Screening Data | <input type="checkbox"/> Procedure Reports | <input type="checkbox"/> Correspondence |
| <input type="checkbox"/> Progress/Provider Notes | <input type="checkbox"/> Lab reports/Pathology | <input type="checkbox"/> Billing |
| <input type="checkbox"/> Other: _____ | | |

Your initials are required to release the following information:

_____ Mental Health Records	_____ Drug, alcohol, or substance abuse records
_____ Genetic information	_____ HIV/AIDS Test Results/Treatment
_____ Psychotherapy Records	

Acknowledgement of Understanding:

- I understand the expiration date of this authorization is _____ or 1 year from today's date, whichever is sooner.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance on it.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
- I understand this consent for release of alcohol and/or drug abuse information is subject to revocation at any time except to the extent that the program or person, which is to make the disclosure, has already acted in reliance on it.
- I understand Marathon Health may not condition my treatment, payment, enrollment or eligibility for benefits on my signing this authorization.
- I understand I am entitled to receive a copy of this form after I have signed it.
- I understand a photocopy or fax of this form is the same as the original.

Signature of Participant or Representative

Today's Date

Relationship to patient (circle one): Self Parent Legal Guardian Other: