



## Authorization to Release Protected Health Information

I hereby authorize Medical Network to release information from the records of:

Member Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ ID#: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

This information will be released to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City and State: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Treatment Dates: \_\_\_\_\_

Description of information to be released: \_\_\_\_\_

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**Failure to initial any of the following will invalidate this authorization and Medical Network will not release the information requested.**

\_\_\_\_\_ I acknowledge and hereby consent that the released information may contain alcohol abuse or alcohol testing information.

\_\_\_\_\_ I acknowledge and hereby consent that the released information may contain drug abuse or drug testing information.

\_\_\_\_\_ I acknowledge and hereby consent that the released information may contain behavioral or mental health services information.

\_\_\_\_\_ I acknowledge and hereby consent that the released information may contain HIV testing, HIV results, or AIDS information.



I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary and the disclosure is made at my request. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present the written revocation to the department that I have authorized to release the information. I understand that the revocation will not apply to information that has already been released in response to this authorization. I need not sign this form to ensure health care treatment.

This authorization expires \_\_\_\_\_ or 180 days from the date signed below and covers only treatment for the dates specified above.

\_\_\_\_\_  
Signature of member or legal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Legal representative's name, address and phone

If signed by legal representative, relationship to member:  
\_\_\_\_\_

Fees/charges will comply with all laws and regulations applicable to the release of information.