PATIENT AUTHORIZATION FORM FOR RELEASE OF MEDICAL INFORMATION

GERIL THERAPY

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that the released information may be subject to re-disclosure by the recipients and no longer be protected by federal privacy regulations.
PATIENT:_____DATE OF BIRTH:_____

Persons/organizations providing the information:

_____

_____

Specific description of information (including date(s)): _____

_____

_____

What is the purpose of use or disclosure of patient information?: _____

_____

_____

The patient or the patient's representative must read and initial the following statements:
1. I understand that this authorization will expire on ____/____/_____ (DD/MM/YEAR) Initials:
If I fail to specify an expiration date, this authorization will expire 12 months from the date signed _____ or after this event.

2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it won't have any effect on any actions the Provider Organization performed before it received the revocation. Initials:

3. I understand that I may refuse to sign this form and that my health care and the payment for my health care will not be affected if I do not sign this form. Initials:

_____ _____

Signature of patient or patient's representative **Date**
(Form MUST be completed before signing.)

If a patient's representative signs this authorization, please complete the following:

_____

Printed name of patient's representative:

_____

Relationship to the patient:

Describe the representative's authority to act for the patient:

_____

_____

_____

Created: 7/6/06
Effective: 7/6/06
Approved by: AG