



AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand this authorization is voluntary. 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, and that it may be re-disclosed by the recipient.

Date of Birth: _____

Patient Name: _____ Social Security #: _____

Organization Providing the Information: UNION MEDICAL GROUP

Organization(s) or Person(s) Receiving the Information: _____

Specific Description of Information Disclosed:

To the extent any of the following information is contained in the records being released, I specifically authorize the release of such information for the purposes indicated below by initialing before each category: Initials: _____ HIV/AIDS testing, test results, treatment and related information including high risk behavior documented; Initials: _____ drug and/or alcohol diagnosis, treatment, test results and reports and referral information; Initials: _____ mental health treatment information, test results and reports including psychological and psychiatric studies, reports, evaluations and referral information: and/or Initials: _____ venereal disease information.

Purpose of Disclosure: _____

If this Authorization is for marketing purposes, remuneration is/is not involved (Provider circle one)

You must read and initial the following statements:

1. I understand this Authorization will expire on __/__/__ (DD/MM/YR) or on the following event _____. Initials: _____

2. I understand that I may revoke this Authorization at any time by notifying UNION MEDICAL GROUP in writing, but if I do, it will not have any effect on any action UNION MEDICAL GROUP took before they received the revocation. Initials: _____

Signature of Patient or Representative _____ Date: _____

Relationship to Patient _____

You may refuse to sign the Authorization. We cannot condition treatment on your signing this Authorization.