



AFFILIATED WITH SANTÉ PHYSICIANS
A MEMBER OF SANTÉ FOUNDATION MEDICAL GROUP & PART OF SANTÉ HEALTH FOUNDATION

**AUTHORIZATION TO DISCLOSE PROTECTED HEALTH
INFORMATION AT THE REQUEST OF THE PATIENT/PATIENT REPRESENTATIVE**

At the request of _____ (patient/patient representative),

This document authorizes _____ (hospital/clinic/office/physician)

To disclose protected health information from the records of _____

(patient name) to _____ (hospital/physician/self/other).

☐	I agree that any and all health information may be disclosed, including but not limited to mental health, drug or alcohol use, HIV/AIDS test results and any other records protected by state or federal laws. OR...
☐	I request that release of protected health information be restricted to the following portions of the medical record:

_____ I understand that information released by this authorization may be disclosed by the recipient and may no longer be protected by federal and state law.

_____ I understand that I have the right to revoke this authorization, **in writing**, at any time by sending such written notification to the practice at (office mailing address)

_____ I understand that a revocation is not effective to the extent that my physician has already disclosed the health information.

_____ I understand this authorization ends on _____ (date).

Patient/Patient Representative Signature Date

Signature Witness Date

Patient Representative:

☐ Parent/Guardian of Minor Patient

☐ Guardian/Conservator

☐ Next of Kin/Executor of Deceased