



AUTHORIZATION FOR RELEASE OF INFORMATION

Section A: Must be completed for all authorizations

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 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.

Patient Name: _____ DOB: _____ Greenway ID#: _____
Patient Address: _____
Patient Contact Phone Number: _____

Persons/organizations providing the information

Persons/organizations receiving the information:

The following information from the above patient's medical record is to be released:

All information on file X-Ray Reports Discharge Summary
 History & Physical Consultation All Test Results
 Other (specify) _____

Section B: Must be completed for all authorizations

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/YR) Initials: _____
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it will not have any effect on the actions they took before they received the revocation.
Initials: _____

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

Date

Printed Name of patient's representative: _____

Relationship to the patient: _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

You may not use this form to release information for treatment or payment except when the information to be released is psychotherapy notes or certain research information.