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AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient Name (include middle initial):

Previous Name (if applicable):

Date of Birth:

I HEREBY REQUEST AND AUTHORIZE THE FOLLOWING RELEASE OF INFORMATION:

INFORMATION TO BE RELEASED BY:

Provider/Organization:

Address:

Phone: Fax:

INFORMATION TO BE RELEASED TO:

Provider/Organization:

Address:

Phone: Fax:

PURPOSE OF DISCLOSURE:

REQUESTED RECORDS:

I understand that this authorization, unless expressly limited by me in writing, will extend to all aspects of treatment including testing and/or treatment for sexually transmitted diseases, HIV (AIDS virus), substance abuse, or mental health conditions.

I understand that I do not have to sign this authorization in order to get health care benefit (treatment, payment, enrollment, or eligibility for benefits) except if I receive healthcare when the sole purpose of the healthcare is to create health information for a third party.

I understand that: a) I must revoke my authorization in writing and may do so by completing and signing the Revocation of Authorization form available at my clinic's business office; b) If I revoke my authorization, it will not affect any actions already taken by Dr. Burkhart based upon this authorization; and c) I may not be able to revoke this authorization if the purpose of it was to obtain insurance.

If Dr. Burkhart is the provider disclosing health information based upon this authorization, the recipient may re-disclose it in some situations. Privacy laws may no longer protect the information. I understand that this authorization does not permit the release of information related to health care provided to me more than twelve months after the date of this authorization.

I release Dr. Burkhart and his staff from all legal responsibility or liability that may arise from the release of this information.

Date | Signature of patient or patient's authorized representative | Relationship to patient if not patient