HPR
TREATMENT CENTERS

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

1. Patient Information

Name – Last, First, MI		
Street Address		
City	State	Zip Code
	Birthdate	Phone No.

2. Information to be Disclosed. (Please check only one box)

- ❒ Records pertaining to: _____
- ❒ Complete copy of official medical record
- ❒ Other (describe): _____

3. Disclosed BY:	**4. Disclosed To:**
Name – (e.g. Health Facility, Physician…)	Name – (e.g Physician, Patient…)
Address	Address
City State Zip Code	City State Zip Code

5. Purpose or need for disclosure. (Please check all applicable categories)

- ❒ further medical care
- ❒ payment of insurance claim
- ❒ application for insurance
- ❒ vocational rehabilitation
- ❒ patient use
- ❒ disability determination
- ❒ transfer care to another physician
- ❒ other: _____

6. This authorization will remain in effect until the 90 days from below date unless you specify that this authorization will be effective for an additional time period. (To specify an additional time period, please check the box below and indicate date. NOTE that if you specify an additional time period, this authorization will apply to your medical information generated during the additional time period.)

- ❒ Other specific expiration date:_____(mm/dd/yy)

In accordance with the conditions listed above, I authorize the use and/or disclosure of my medical information. This authorization includes disclosure of information regarding psychiatric consults and mental illness, developmental disabilities, with the following exception(s):

Exception(s):

_____

Signature of Patient

_____

Date (mm/dd/yy)