AUTHORIZATION FOR USE OR RELEASE OF MEDICAL INFORMATION

To: _____ (Insert name of Jail / Provider / Entity)

I hereby voluntarily authorize the use or disclosure of my individually identifiable health information and/or miscellaneous personal information ("Protected Information") as described below in this authorization form to _____
I also intend that a photocopy of this document have the same force and effect as the original.

Individual / Inmate*: _____ Social Security Number: _____
**the person releasing the information*

Type of information to be released (check all that apply):

☐ Admission Summary	☐ Radiology Reports	☐ Psychological Evaluations
☐ Discharge Summary	☐ Laboratory Reports	☐ Physical Therapy
☐ History & Physical	☐ Physical Evaluations	☐ Emergency Room
☐ Consultative Reports	☐ Psychiatric Evaluations	☐ Clinic Notes
☐ Operative Reports	☐ Diagnosis & Treatment	☐ Alcohol & Drug Abuse

Other _____

Dates of Service (if known) _____ Patient Number _____

I direct that this authorization will expire on _____ (10 years from today)

The Protected Information is being released at the request of the individual for the purpose of the Authorized Recipient's information.

I understand that I may refuse to sign this Authorization, and that my health care treatment, payment, enrollment or eligibility for benefits will not be conditioned upon signing this form. I also understand that my Protected information is subject to re-disclosure to the Authorized Recipients of the Protected information pursuant to this Authorization and that, once released, the Protected Information may no longer be protected by federal privacy regulations.

I also understand that I may revoke this Authorization at any time by notifying the Releasing Party in writing, but if I do, the revocation will not have any effect on any actions the Releasing Party or Authorized Recipients took before the receipt of the revocation of this Authorization. I understand that I may see and copy the Protected Information described on this Authorization, if I request to do so in writing, and I understand that I will receive a copy of this Authorization after I sign it.

(*Form MUST be completed before signing*)

_____ _____
Signature of individual / inmate or of individual's representative Date

_____ _____
If applicable, printed name of individual's representative Relationship to the individual

_____ _____
Witness Date