



5350 E. Erickson Drive
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AUTHORIZATION TO USE OR DISCLOSE HEALTH CARE INFORMATION

I HEREBY AUTHORIZE

Quality of Life Facilities / Doctors Name:
Address: City/State: Zip:
Phone: Fax:

TO RELEASE

\$25.00 for Complete Chart Record: (\$0.00 if requested to be delivered to Physicians Office)
Chart Notes: ALL Specify:
Labs/Reports: ALL Specify:
Other: ALL Specify:

FROM THE HEALTH RECORDS OF

Patient Name: D.O.B:
Patient Address: Daytime Phone:
Are you authorizing the release of your own medical records? YES NO
If not, what is the name and relationship to the patient?
Name: Relationship:

TO BE RELEASED TO

Quality of Life Self (please indicate mailing address below)
Facilities / Doctors Name:
Address: City/State: Zip:
Phone No.: Fax:

FOR THE PURPOSE OF:

Concurrent Care Transfer of Care At My Request Other:

MY RIGHTS

I understand that unless revoked, this authorization is valid for 1 year from the date of signing. I understand that I may revoke this authorization in writing at any time except to the extent disclosure has already been made in accordance with this document. Also, I understand that I do not have to sign an authorization as a condition for receiving treatment or healthcare benefits (treatment, payment or enrollment). However, I do have to sign an authorized form to take part in a research study or to receive health care when the purpose is to create health care information for a 3rd party.

Unless specifically excluded, this authorization includes release of specially, protective information requiring my explicit authorization or release. This includes referrals, diagnosis and treatment information related to: (check the accompanying box(s) below to EXCLUDE the information authorization):

- Substance Abuse Mental Health Condition Sexually Transmitted Diseases
Genetic Testing HIV/AIDS

I understand that once healthcare information is disclosed, the person or organization that receives it, may re-disclose it, and that it may no longer be protected by privacy law.

Patient Signature: Date:
Representative/Guardian Signature: Date: