Authorization for Disclosure of Health Information

(1) I hereby authorize _____ to
(Name of Releasor e.g., Highmark Blue Shield or other entity)

Release/disclose the following information of:

Patient/Member Name _____ Date of Birth _____

Address _____

Identification Number _____ Telephone _____

The records to be disclosed cover the following period(s):

From (date) _____ To (date) _____

From (date) _____ To (date) _____

(2) Check if this authorization is for psychotherapy notes.

<If this authorization is for psychotherapy notes, you must *not* use it as an authorization for any other type of protected health information.>

(3) Information to be disclosed (Please check only that which applies):

Designated Record Set: (Please check only that which applies.)

Enrollment Information Claims Information Payment Information

Managed Care Information (Precertification, 2nd Opinions, Treatment Plans, Care Coordination, Case Management, etc.)

AND/OR

- Pharmaceutical information
- Consultation reports
- X-ray reports
- Discharge summary
- Progress notes
- Explanation of Benefits
- History and physical examination
- Laboratory tests
- Complete health record(s)
- Other (please specify) _____

I understand that this will include information relating to (check if applicable):

- Acquired Immunodeficiency Syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV)
- Mental health care
- Treatment for alcohol and/or drug
- Sexually transmitted disease
- Other (please specify) _____