Authorization to Release Medical Information

Patient Information:

Name: _____ Date: _____

Address: _____ Phone: _____

Social security number: _____ Date of birth: _____

My medical information is to be disclosed to:

(Exclusive of psychiatric and or drug/ alcohol treatment facilities)

Attention:_____

Address: _____

City/State: _____

Phone: _____ Fax: _____

Description of information to be disclosed: _____

_____

I understand the following:

- I may revoke this authorization at any time by providing written notice to Quadra Health Institute (QHI).
- I may not be able to revoke this authorization if QHI has already taken action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance coverage.
- QHI will not condition treatment or payment based on my signing this authorization.
- I am signing this authorization freely.
- No one has pressured me to sign this authorization.
- The information disclosed in this authorization may be subject to re-disclosure by QHI and no longer protected by federal law.
- I acknowledge that I have had an opportunity to review this authorization and understand the intent and the use.
- A copy of this authorization shall be as valid as the original.
- I understand that I have a right to receive a copy of this authorization if requested by me.
- I hereby authorize QHI the use and disclosure of my protected health information (information about me in my medical records and financial records).
- I understand that if I don't fill this form out entirely my information may not be released.

Patient signature: _____ **Date:** _____

Witness signature: _____ **Date:** _____

QUADRA

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