

**AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION**

A COPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL

**My Information should be released FROM:**(select only one)

Boynton Health (address/FAX above)

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**My Information should be released TO:** (select only one)

Boynton Health (address/FAX above)

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Patient Identifying Information:**

Name (Please print): \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Patient ID# \_\_\_\_\_  
 Preferred Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Work: \_\_\_\_\_

**How to Release (select only one):**

Mail the information to the address written above.

Fax the information to the fax number written above.

I or \_\_\_\_\_ (valid photo ID required) will pick up the records on \_\_\_\_\_. Allow one week unless other arrangements are made.

Other (specify): \_\_\_\_\_

**I authorized the release of:**

Printed copy of my records  Form(s) **and/or** Letter(s).

Other (explain) : \_\_\_\_\_  Verbal exchange of information between parties.

\_\_\_\_\_

**The purpose of this release is:**  Continuing care.  
 Other: \_\_\_\_\_

**Information to be released:** (select all that apply)

**Specific Visit, Date(s)/Condition(s):** \_\_\_\_\_

**Clinical records:** (specify)  Billing/Finance records  Eye Clinic Notes

Clinic/Progress notes  Radiology reports  Laboratory/Pathology records  EKG reports

Immunizations.  TB screening  HIV/AIDS treatment  Films/Slides/Images/CDs.

**Dental Clinic records**  **Dental xrays**  **Psychiatric records**  **Chemical Dependency/Substance Use Dis.**

**Other:** \_\_\_\_\_

**These records require specific consent for release and may not be combined with any other consent on the same page:**

Psychotherapy notes.  Couples/Family Therapy - **Each party must complete a separate form.**

- I understand that I may revoke this authorization by written request at any time to the address at the top of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization. **This authorization will expire one year from the date of my signature unless a different expiration date is entered here:** \_\_\_\_\_
- I understand that once information is released pursuant to this authorization, Boynton Health cannot prevent the re-disclosure of the information to another third party.
- I understand there may be a charge associated with the release of information services rendered. There is no charge for release of information to other health care facilities for continuing care.
- I understand that my treatment will not be conditioned on my signing this authorization except for research-related treatment.
- I understand that I am entitled to a copy of this *Authorization for the Release of Health Information*.

\_\_\_\_\_  
 Signature of Patient/Authorized Person

\_\_\_\_\_  
 Authorized Person's authority to sign

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Printed name of Authorized Person (legal name)

REASON PATIENT CANNOT SIGN:  Minor  Deceased  Other: \_\_\_\_\_

**OFFICE USE ONLY**

Fee	Received by: _____	Completed by: _____
	Filed by: _____	Date sent: _____

**rev 01/27/23**