



AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

I authorize Art of Health to release my health information to:

Name/Title: _____

Address: _____

Telephone: _____ Fax: _____

- Type of Information:** Complete Medical Record Labs Only MD Progress Notes
- Specific Dates of Treatments _____

Notice: Art of Health is required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

Your Rights: This authorization to release health information is voluntary. This authorization may be revoked at anytime. The revocation must be in writing, signed by you or your representative. You are entitled to receive a copy of this authorization.

Expiration of Authorization: Unless otherwise revoked, this authorization expires on _____ (insert applicable date) If no date is indicated, the authorization will expire 12 months after the date of my signing the form.

Print Name

Signature (Patient, Parent, Guardian)

Date