ATTACHMENT B TO FORMAL ATTORNEY GENERAL OPINION
Authorization for Disclosure of Protected Health Information

I authorize _____
(name/address of provider) to release the health information of the individual named below:

Patient Name _____
Address _____
Phone Number _____ DOB_____

I authorize the information to be disclosed to and discussed with the following individual(s) or organization(s):

Name _____ Organization _____
Address _____

For the purpose of investigation and/or prosecution within
_____.

The type and amount of information to be disclosed is as follows: *(specify dates where appropriate)*

- Entire Medical Record, from date _____ to date _____
- Radiological Reports and films, from date _____ to date _____
- Laboratory Results, from date _____ to date _____
- Ambulance trip sheet in your possession, from date _____ to date _____
- Other: _____(you must specifically indicate the release of records relating to drug or alcohol abuse, child abuse, HIV status, genetic testing, sickle cell anemia, or mental health records. A separate authorization is required for release of psychotherapy notes.)

I understand this authorization will expire, without my express revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on this authorization. I understand that I have a right to a copy of this authorization.

I understand that authorization for the disclosure of this health information is voluntary and I can refuse to sign this authorization. Treatment, payment, enrollment in the health plan or eligibility for benefits may not be conditioned on obtaining the individual's authorization. I understand that any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by federal confidentiality rules.

_____ _____

Signature of Patient or Authorized Personal Representative Date

_____ _____

Personal Representative's Name (print) and Relationship Date

This authorization reflects the requirements of HIPAA, 45 C.F.R. § 164.508.