AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION TO A DESIGNATED PARTY

Today's Date: _____

Patient Name: _____

Provider Name: _____

Department/Practice: _____

Designated party: _____

Relationship to Patient: _____

Address: _____

Phone:_____ Fax: _____

The information will be used or disclosed for the following purposes:

___ At the request of the individual ___Other_____

This Authorization grants permission to the Designated Party named above to:
____ have access to my medical record information
____ have access to my billing & insurance information
____ have access to any test results
____ make or confirm appointments
____ other, please specify_____

I authorize APNS to use and disclose my health information as described in this authorization. The patient or the patient's representative must read and initial the following statements:

1. I understand that this information will: (Must check one)
   ___expire 1 year from the date signed by the patient or patient's representative; or
   ___only when revoked by the patient
2. I understand that I may revoke this authorization at any time by notifying in writing the above named Provider Practice at APNS; however, if I do revoke the authorization, it will not have any effect on any actions taken by APNS prior to their receipt of the revocation
3. I understand that this authorization is voluntary
4. I understand that once this information is released to the Designated Party, i.e. the released information may no longer be protected by federal privacy regulations
5. I understand that my treatment cannot be conditioned on whether I sign this authorization

_____ _____
Signature of patient or patient's representative Date
(Form MUST be completed before signing or will not be valid)

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