CANOPY COVE
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

SECTION I – Patient Information

Patient Name	Date of Birth MM DD YYYY	Telephone Number
Street Address	City, State,	Zip

SECTION II – Health Information

I hereby authorize and request ____________________ [PROVIDER'S NAME] and office staff at [CENTER NAME] to release or receive confidential information including my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions, including records related to:

Initial each to approve release: ____ **Mental Health** ____ **Alcohol/Drug Abuse Treatment** ____ **Genetic Information**

____ **Communicable Diseases including but not limited to HIV/AIDS**

SECTION III – Recipient Information

Individual/Organization Name		Telephone Number
Street Address	City, State, Zip	Fax Number

______ (*please initial*) I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

SECTION IV – Reason for Disclosure

Please detail the reasons why information is being shared. If you are initiating the request for sharing information and do not wish to list the reasons for sharing, write '*at my request*':

____

SECTION V – Revocation

I understand that I am permitted to revoke this authorization to share my health data at any by notifying, in writing, the [CENTER NAME]. I further understand that:

- If my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.
- I understand that I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in Section III.
- I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

SECTION VI – Signature

By signing my name below, I certify that this information can be used for the purpose of processing my Authorization for Release of Medical Information request.

____ ________/________/________
Signature of Patient or Legal Representative Date

____ ______________________
Printed Name of Patient or Legal Representative Relationship to Patient

____
Patient Representative's Authority to Act for Patient (*attach supporting documentation*)