ACORN
HEALTH SERVICES

Authorization For Release of Information

Patient Name_____ Date of Birth_____

I hereby authorize Acorn Health Services to:

__Release my medical records to be picked up at the office

__Release my medical records to: __Obtain my medical records from:

Name/Facility:_____

Address_____City_____

State_____Zip_____Phone_____Fax_____

I authorize release of all my medical records except those checked below:
__HIV/AIDS diagnosis and treatment __Genetic test results

__Alcohol and Drug Abuse Records __Sexually Transmitted Diseases

__Psychiatric Health including Behavioral Medicine

__Other: Please list_____

I understand:

*I may withdraw my authorization at any time by submitting a written request to the office where I originally submitted the authorization (except to the extent action has already been taken).
*Authorizing disclosure of health information is voluntary. I do not need to sign this form in order to assure treatment.
*Information released on this authorization, if redisclosed by the recipient, is no longer protected by Acorn Health Services.
*This authorization will expire on _____(specify date) or, if no date is specified, automatically expires in 12 months from the date of signing.

I have read and understand the above and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

Print Name_____Date_____

Patient's Signature_____

If patient is a minor, or not competent to give consent, the signature of parent, guardian or legal representative is required.

Print Name_____Relationship to Patient_____

Signature of Legal Representative_____

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