AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO LAW ENFORCEMENT AGENCY

I authorize **INSERT NAME OF PROVIDER OR CLASS OF PROVIDERS** to disclose protected health information ("PHI") from the records of:

Patient Name:

Patient Address:

Phone Number: Patient Birthdate:

I authorize PHI to be disclosed to:

Name of Law Enforcement Agency:

Address of Law Enforcement Agency:

Agency Phone Number:

Contact Person of Law Enforcement Agency (if applicable):

Specific description of the information to be disclosed, including the dates of service:

Specific description of the purposes of the disclosure:

I authorize the provider to disclose information related to the following types of care (check all that apply, if any):
☐ AIDS/HIV and other Communicable Diseases
☐ Behavioral Health Care/Psychiatric Care/Mental Health Information
☐ Alcohol and/or Drug Abuse Treatment
☐ Genetic Testing Information

I understand that the provider will not deny me treatment if I do not wish to sign this form. I may refuse to sign this authorization form. I also understand that I may revoke this authorization at any time, unless the provider has already relied on my authorization to disclose health information to the law enforcement agency named above. To revoke my authorization, I must submit a written request to:
Name of Provider:

Address of Provider:

City: State: Zipcode:

Contact Person of Provider: Phone Number of Provider:

Unless I revoke this authorization earlier, it will expire on the following date, event, or condition:

I understand that, if this information is disclosed to the law enforcement agency, the information may no longer be protected by the federal privacy regulations and may be redisclosed by that agency. I understand the matters discussed on this form. I release the provider, its employees, officers and directors, medical staff members, and agents from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

____
Signature of Patient Date

____ __________________________
Signature of Legal Representative Relationship to Patient or
Description of Authority to Act for Patient

When serving this document to the hospital/doctor you must attach your business card in the lower right hand corner!