CENTER FOR MEN

REQUEST FOR RELEASE

In accordance with federal privacy laws, this form should be completed if you desire that your protected health information be released to a person or organization of your choosing. By completing this form it authorizes Center for Men to provide protected health information to the person or organization that you have chosen. You may revoke this in writing at any time.

Your Information

Name: _____

Address: _____

DOB: _____

Cell/home phone: _____

SSN: _____

I authorize the medical staff at Center for Men to release my protected health information to the person or entity listed below:

Recipient/person or entity to receive your information:

Name: _____

Relationship: _____

Telephone number/fax: _____

Address: _____

Manner of release:

- o Pick up only
- o Mail to recipient (this choice may compromise your private information)

Information to be released:

- o Information related to payment, benefits, services
- o Specific information listed below

Specific Release:

- o Genetic information _____(initial)
- o Substance abuse/alcohol abuse____(initial)
- o HIV/AIDS_____(initial)
- o Mental/Behavioral health____(initial)

Purpose of release: _____

This authorization will expire:

- o When I revoke this authorization
- o Upon this date: _____

Affirmation and request for release of information:

"I affirm that all of the preceding information is true and correct to the best of my knowledge and that this release is voluntary and not conditional to receive treatment. I also understand that if the person or organization that I release my information to is not subject to federal health information and privacy laws, they may further release my information and it may no longer be protected by federal privacy laws. I hereby request that center for men release my protected health information to the person or organization listed above."

Patient Name _____

Patient Signature _____

Date _____

This release will expire in 180 days. Please keep a copy of this and the notice of privacy practice for your records.