

**G. A written authorization to allow release of an individual's health records shall substantially include the following information:**

**AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH RECORDS**

Individual's Name .....  
.....

Health Care Entity's Name .....  
.....

Person, Agency, or Health Care Entity to whom disclosure is to  
be made .....  
.....

Information or Health Records to be disclosed .....  
.....

Purpose of Disclosure or at the Request of the Individual .....  
.....

As the person signing this authorization, I understand that I am giving  
my

permission to the above-named health care entity for disclosure of  
confidential health records. I understand that the health care entity m  
ay not

condition treatment or payment on my willingness to sign this authoriza  
tion

unless the specific circumstances under which such conditioning is perm  
itted

by law are applicable and are set forth in this authorization. I also  
understand that I have the right to revoke this authorization at any ti  
me, but

that my revocation is not effective until delivered in writing to the  
person

who is in possession of my health records and is not effective as to he  
alth

records already disclosed under this authorization. A copy of this  
authorization and a notation concerning the persons or agencies to whom  
disclosure was made shall be included with my original health records.  
I

understand that health information disclosed under this authorization might be

redisclosed by a recipient and may, as a result of such disclosure, no longer

be protected to the same extent as such health information was protected by

law while solely in the possession of the health care entity.

This authorization expires on (date) or (event) .....  
.....

Signature of Individual or Individual's Legal Representative if Individual is

Unable to Sign .....  
.....

Relationship or Authority of Legal Representative .....  
.....

**Date of Signature .....**