



# AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

By signing this form, I authorize the physician/person/facility/entity listed below to release my confidential health information to Costus Medical.

**Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Maiden Name:** \_\_\_\_\_ **SSN:** \_\_\_\_\_ **Gender**  M  F

Release my protected health information from the following physician/person/facility/entity:

Name:		
Address:		
City:	State:	Zip Code:
Phone:	Fax:	

The information you may release subject to this signed release form is as follows:

- History and Physical (within 1 year) Year Date:
- Lab Reports (minimum to include CBC, CMP, C-peptide, U/A, Micro Albumin and Hgb A1c)
- Medication Record
- Medical Release from Physician/Doctor
- Other: \_\_\_\_\_

**Information pertaining to the following will not be released unless specifically authorized by marking the relevant box(es):**

- Drug and alcohol abuse, diagnosis or treatment
- HIV/AIDS test results, diagnosis or treatment
- Mental health diagnosis or treatment
- Genetic testing

**Expiration of Authorization:** Unless otherwise revoked, this authorization expires on \_\_\_\_\_  
If no date is indicated, the authorization will expire 12 months after the date of my signing this form.

\_\_\_\_\_  
Patient's or Patient's Representative's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness



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## AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION FROM

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(Name of Clinic)

By signing this form, I authorize Costus Medical to release my confidential health information to the physician/person/facility/entity I direct.

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Maiden Name: \_\_\_\_\_ SSN: \_\_\_\_\_ Gender:  Male  Female

Please specify the health information you authorize to be released:

Type(s) of Health information: \_\_\_\_\_

Date(s) of treatment: \_\_\_\_\_

**Expiration of Authorization:** Unless otherwise revoked, this authorization expires on \_\_\_\_\_  
If no date is indicated, the authorization will expire 12 months after the date of my signing this form.

\_\_\_\_\_  
Patient's or Patient's Representative's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient