

**Pathology Associates**

**Authorization for Release of Health Information**

Patient's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

SSN: \_\_\_\_\_ Previous name: \_\_\_\_\_

**I authorize Pathology Associates to release/distribute the protected health information described below to:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Purpose of disclosure: \_\_\_\_\_

(Request of patient for employment, life, disability insurance, etc.)

Date required: \_\_\_\_/\_\_\_\_/\_\_\_\_

Information will not be resent without additional authorization. This authorization expires upon fulfillment of this request unless special circumstances are noted below. The patient or their representative may revoke this authorization by notifying Pathology Associates in writing.

**I authorize the following information to be released/distributed to the person/organization listed above:**

\_\_\_ Copies of all medical records for the period \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_ Copies of the information described below for period \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

I understand that there may be information in these records that I would not want released. I understand that this information may include any history of acquired immunodeficiency syndrome (AIDS); sexually transmitted diseases; human immunodeficiency virus (HIV) infection; behavioral health service/psychiatric care; treatment for alcohol and/or drug abuse; or similar conditions.

The following information should *not* be released, even if occurring during the dates above:

Pathology Associates has a detailed document called the "Notice of Privacy Practices". A copy of this document may be found at the Reception desk and on-line at [www.kwbpathology.com](http://www.kwbpathology.com). This document contains more information about the policies and practices protecting the patient's privacy. I understand that I have the right to read the "Notice of Privacy Practices" before signing this authorization.

I understand that Pathology assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release Pathology Associates from all legal liability that may arise from this authorization.

I have been informed of any charges that may be associated with this authorization.

Federal law states that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is prohibited by the HIPAA Privacy Rule. Federal Law also requires a statement that there is the potential for the protected health information released under this authorization to be subject to re-disclosure by the recipient.

\_\_\_\_\_  
Patient or legally authorized individual signature Date Time

\_\_\_\_\_  
Relationship to patient, if signed by anyone other than the patient  
(parent, legal guardian, personal representative, etc.)