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**MANNING  
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**Authorization To Receive/Release Health Information**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

**I hereby authorize the disclosure of my health information FROM:**

The following information from my medical record, Physician Office Notes, Consultation Reports, Procedure Reports, Pathology Reports, Laboratory Reports, Imaging Reports, All other Diagnostic Studies, Psychiatric and Psychological Evaluations, Therapy Notes, Mental Health Progress notes, etc.

Name of Person/Organization Releasing Information	
Address	City/State/Zip
Phone Number/Fax Number	

**To release my information TO:**

Name of Person/Organization Releasing Information	
Address	City/State/Zip
Phone Number/Fax Number	

**Information to be released:**

Medical Records for specific Dates of Service (please list) from \_\_\_\_\_ to \_\_\_\_\_  
 Other (please list) \_\_\_\_\_

**This authorization remains in effect until the information has been forwarded as requested.**

**RIGHTS OF THE PATIENT:**

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that the information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. *Any information received by this office for our own use will continue to be projected by the Federal Privacy Rule (HIPPA).* I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document by written notification. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

X \_\_\_\_\_  
Printed Name of Patient or Personal Representative

X \_\_\_\_\_  
Signature of Patient or Personal Representative      DATE

\_\_\_\_\_  
Description of Personal Representative's Authority (attach necessary documentation)

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Date Sent: \_\_\_\_\_ By: \_\_\_\_\_ Via: \_\_\_\_\_  
MRREG 01 10/2021