



HIPAA AUTHORIZATION FOR RELEASE OF PATIENT MEDICAL RECORDS AND INFORMATION (Please print legibly in black ink)

Patient Name: Last First M.Initial

Patient's Date Of Birth: Patient's Allergies:

Patient Address: Street

City: State: Zip:

CONTACT INFORMATION FOR PROVIDER FROM WHOM RECORDS ARE BEING REQUESTED

Providers Name:

Organization, Facility Name:

Providers Address:

Phone: Fax:

City: State: Zip:

By evidence of signature below, the above named patient has requested medical records as specified below be released to National Association Of Affordable Healthcare, ("NAAHC") for continuity of care and to facilitate research into the long-term effectiveness of current protocols as well as the efficacy of alternative therapies for patients with chronic medical complaints. The patient expressly releases this information to NAAHC.

- All general medical records, radiological reports, and lab reports.
Limited records(specify):
Including psychiatric/psychological records (if applicable).
Including HIV/AIDS records (if applicable). Patient signature:
Other (specify):
Records required only for period of treatment on or about (enter dates): to

The patient also agrees that all information provided is accurate and that they are over the age of 18.

Signature

Date

ACKNOWLEDGEMENT OF PROHIBITION ON REDISCLOSURE

NAAHC acknowledges that this information is being disclosed from records whose confidentiality is protected by law. State and federal laws prohibit us from making any further disclosure of such information without the consent of the person to whom such information pertains, or as otherwise permitted by such laws. With regard to HIV/AIDS and psychiatric/psychological records (if applicable), a specific, written consent or a court order is required. A general authorization for the re-release of medical information is NOT sufficient for this purpose.