RAE E. DRAZIN, Ph.D.
PATIENT ADVOCATE

# AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION

**1**. I authorize _____ to disclose the protected health information of the patient described below to RAE E. DRAZIN, Ph.D, PATIENT ADVOCATE.

Patient Name: _____ DOB: _____

**2**. I authorize (**please circle A or B**):

A. The release of my complete health record (including records relating to mental healthcare, communicable diseases, and treatment of alcohol or drug abuse.

B. The release of my complete health record with the exception of the following information:

- Mental health records
- Communicable diseases (including HIV and AIDS)
- Alcohol/drug abuse treatment
- Other (please specify): _____

**3**. This authorization for release of information covers the period of healthcare (**please circle A or B**):

A. All past, present and future periods.

B. From _____ To _____

**4**. I understand that I have the right to revoke this authorization, in writing, at any time.

_____
Signature of patient or personal representative

_____
Printed name of patient or personal representative and relationship to patient

Date: _____

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