

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____ authorize _____
(Patient's Name – Please Print) (Releasing Physician/Facility)

whose address is _____
(Street, City, State, Zip Code, Phone/Fax Number)

to release information from the medical record of:

(Patient Name) (Birth Date) (Social Security No.)

(Current Street Address, City, State, Zip) (Current Phone No.)

To: _____

Address: _____

St./City/Zip: _____

Phone No.: _____

Fax No.: _____

Dates Requested: From: _____ To: PRESENT _____

Please check information to be released (Reports may include information on drug, alcohol, psychological, HIV or communicable disease treatment.):

- | | |
|---|--|
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> HIV / AIDS, if applicable |
| <input type="checkbox"/> Laboratory | <input type="checkbox"/> Consultations |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Radiology / MRI / CT |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> ALL |

Purpose for release of information:

- | | |
|---|---|
| <input type="checkbox"/> Personal Use | <input type="checkbox"/> Continuing Medical Care |
| <input type="checkbox"/> Legal Purposes | <input type="checkbox"/> Social Security / Disability |
| <input type="checkbox"/> Insurance | <input type="checkbox"/> Other: _____ |

I understand that I may revoke this consent anytime except to the extent that action has already been made before receipt of revocation. This authorization expires automatically one hundred eighty (80) days from the date of signature or as otherwise specified. I understand that I will be charged a \$35.00 fee for copies of my medical records. I understand that these records are protected under federal / state law and cannot be disclosed without my consent otherwise provided by law. Releasing office will not be responsible for dissemination or disclosure of your confidential medical information once we provide such information, at your request, to your health insurer, employer, attorney or other designee.

Patient's Name: _____ X _____
(Please Print) (Signature of Patient, Parent/Executor, Legal Rep)