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) (Date of birth) (Social Security number)

_____ _____
(Current address, city, state, zip code) (Current phone number)

To:
ADDRESS: _____
CITY/STATE/ZIP: _____
PHONE NUMBER: _____
FAX NUMBER: _____

Dates requested: From: _____ To:_____

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

____History & physical
____Laboratory
____Progress notes
____Other:_____
____HIV / AIDS, if applicable
____Consultations
____Radiology / MRI / CT
____ALL

Purpose for release of information:

____Personal use
____Legal purposes
____Insurance
____Continuing medical care
____Social Security / disability
____Other:_____

I understand that I may revoke this consent at any time except to the extent that action has already been taken before receipt of revocation. This authorization automatically expires one hundred eighty days (180) from the date of signature or as otherwise specified. I understand that I may be charged a cost-based fee for copies of my medical records in accordance with HIPAA regulations. I understand that these records are protected under federal/state law and cannot be disclosed without my consent unless otherwise provided by law. The releasing office will not be responsible for dissemination or disclosure of your confidential medical information once such information is provided, at your request, to your health insurer, employer, attorney, or other designee.

Patient's name: _____ x _____
(Please print) (Signature of patient, parent, executor, or legal representative)

Date: _____