



Authorization for Release of Medical Information

I, _____, _____/_____/_____, _____
 (Name of patient) (Date of birth) (Phone number) **authorize**

 (Street Address) (City) (State) (Zip)

My records to be released from: _____
 (Name)

 (Street Address) (City) (State) (Zip)

My records to be sent to: _____
 (Name)

 (Street Address) (City) (State) (Zip)

The type of information to be disclosed (check all that apply):

| | Visit Date | | Visit Date | Initials |
|-------------------------------|------------|------------------------------|------------|----------|
| _____ All Records | _____ | _____ Medication Records | _____ | |
| _____ Progress Notes | _____ | _____ X-ray, CT, MRI | _____ | |
| _____ Discharge Summary | _____ | _____ Lab Reports | _____ | |
| _____ History and Physical | _____ | _____ Pathology Report | _____ | |
| _____ Consultation Report | _____ | _____ Mental Health | _____ | |
| _____ Operative Report | _____ | _____ Alcohol/Drug Report | _____ | |
| _____ Procedure: _____ | _____ | _____ Sexually Trans Disease | _____ | |
| _____ Other: _____ | _____ | | | |
| _____ HIV (AIDS) Test Results | _____ | | | |

(Requires your signature here)

The purpose of the disclosure is: (check one)

Medical Care
 Payment of Claim/Benefits
 Personal Use
 Legal Investigation
 Insurance Application
 Other (please specify) _____

Permission to Release Records

I understand that I may revoke this authorization by written notification at any time following this date, except for the information which may have been released prior to the revocation. Unless otherwise specified, this consent will expire one year from the signed date. This authorization will be effective for medical records generated to the date of the signature.

I understand that in accordance with State and Federal confidentiality regulations the information disclosed may include reference to or treatment of alcohol/drug abuse, emotional illness, developmental disability, or psychiatric care only if I indicated above with my initials or signature. Further disclosure of this information without written consent is prohibited by law.

I understand that there may be a fee charged to me to cover the cost of copying and sending my records. This fee will be due and payable before my request for copies of medical records is processed.

Expiration date or condition to expire: 6 MONTHS

 (Signature of person giving consent) (Date signed) (Witness) (Date signed)

The signature is of the _____ Patient _____ Parent of Minor _____ Legal Guardian
 _____ Patient's Executor or Next of Kin
 _____ Person authorized by Patient _____
 (Specify relationship or authority to act)