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AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

I hereby authorize the use and disclosure of my health information. I understand this authorization is voluntary. I understand that if the organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations, and that it may be re-disclosed by the recipient. This form only valid when filled out completely by the patient.

OUR OFFICE WILL ONLY MAIL REQUESTED RECORDS

PATIENT NAME: _____

DATE OF BIRTH: _____

RELEASE THE MEDICAL INFORMATION -

(CIRCLE ONE) **TO** **FROM**

NAME OF PERSON: _____

ORGANIZATION: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE NUMBER: _____

FAX NUMBER: _____

DATES REQUESTED: _____

* Please allow 30 days for your medical records to arrive at their requested location. *

Please Initial if Allowed:

_____ I consent to the release of sensitive medical information, up to and including psychological treatment, drug and alcohol treatment, and/or HIV related treatment.

I also understand that:

- Federal privacy regulations will no longer apply to the information disclosed.
- A copy of this authorization may be utilized with the same effectiveness as an original.
- This authorization will expire **one year** from the date of the signature.
- I understand I can revoke this authorization at any time by writing to the health care provider, but that revoking this authorization will not affect disclosures made or actions taken before the proper letter is received.

_____ _____

PATIENT/PARENT/GUARDIAN SIGNATURE DATE