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Authorization to Release Medical Records

Patient Name: _____ Patient DOB: _____

Information to be released from:

Name of facility or provider: _____
Address: _____
Phone # _____ Fax #_____

Information to be sent to:

Name of designated recipient: _____
Address: _____
Phone # _____ Fax # _____

INFORMATION TO BE RELEASED: (Check One)

___ The most recent 2 years of pertinent information (chart notes, labs, xrays, and special tests)
___ All medical records
___ Specific information (Please Specify): _____

PURPOSE FOR WHICH THE DISCLOSURE IS BEING MADE: (please check one)

___ Attorney ___ Insurance ___ Doctor ___ Personal

Patient Authorization

I understand that my records may contain information regarding the diagnosis or treatments of HIV/ AIDS, sexually transmitted diseases, drugs/ alcohol, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released. **EXCLUDE** the following information from the record released: (please initial)

_____ Drug/ Alcohol abuse/ treatment and diagnosis _____ Sexually transmitted diseases

_____ HIV/ AIDS diagnoses/ treatment/ testing _____ Mental illness/ psychiatric diagnoses/ treatment

My Rights:

I understand I do not have to sign this authorization in order to obtain healthcare benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy notice to patients posted at the facility where your information is being released. I understand that one the health information I have authorized to be disclosed reaches the noted recipient, that person or orginiaztion may re-disclose it, at which time it may no longer be protected under Privacy Laws.

Signature: _____ Date: _____
(Parent, Guardian, or authorized representative) (Expires 90 days from signature)