Authorization/Request for Medical Records

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"This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulation (42DFR Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization of the release of medical or other information is NOT sufficient for this purpose."

Patient Information:

Patient's Name: _____ DOB: _____
Address: _____ City: _____
State: _____ Zip Code: _____ Phone: _____

Requested Records From:

Name: _____
Address: _____
_____
Phone: _____
Fax: _____

Records Released To:

Name: _____
Address: _____
_____
Phone: _____
Fax: _____

Reason for request/disclosure of records:

Reason for Request:
___ Changing of Physician
___ Insurance Request
___ Moving out of Geographical Area
___ Specialist Request for Treatment
___ Parent/Legal Guardian's Copy
___ Other: _____

Records to be included:
___ All Records *
___ Immunization Records
___ Progress Notes
___ Lab Reports
___ Radiology Reports
___ Other: _____

*All records to be disclosed will include communicable disease information, e.g. AIDS information or others. This information gives consent to inspect and copy medical records whose confidentiality is protected by Federal laws which include special authorization to release medical information under the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255) and the comprehensive alcohol abuse and alcoholic prevention, treatment and rehabilitation act amendments of 1974 (9.L. 93-282).
The undersigned hereby authorizes and consents to the disclosure by the above named clinic to the above named company or persons, or their representatives, or the bearer of this instrument of any and all information, records, documents, reports, clinical abstracts, histories, and charts, of every kind and description relating to my condition, care, confinement and treatment, and consent to the furnishing them of photo static copies or other copies of same.
BE IT FURTHER KNOWN that this consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon. If personally requesting a copy of complete medical records, there will be a $25 fee. Records to other physicians will be sent as a free courtesy for the first copy. Subsequent copies may incur a $25 fee.

I, _____ (patient, parent or legal guardian), am authorizing release of medical records as specified. This request is in effect for one year unless otherwise stated.

Signature: _____ Date: _____