Authorization for Release of Medical Information

Patient Full Name: _____ DOB: __ __/__ __/

Previous/Other Name: _____ (If different than above)

This will authorize Kelly Cunningham MD to release medical records to:

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

Medical Information Requested:	☐ I have been referred to another doctor
☐ Lab reports	☐ I am changing doctor (provider)
☐ Immunization	☐ My insurance changed
☐ MRI Report	☐ Complete medical records
☐ Other	☐ Progress notes, with medication list
	☐ Other
	☐ To update my regular doctor (provider)
	☐ I want/need a second opinion
	☐ Dissatisfaction with care
	☐ I am moving (New Address)
	☐ Other

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I specifically authorize the release of data and information relating to (Note, you must mark yes or no):

Yes	**No**	
☐	☐	Substance Abuse (alcohol/drug abuse)
☐	☐	Mental Health/Depression (includes psychological testing)
☐	☐	HIV-Related Information (AIDS related testing)

This consent may be revoked at any time by notifying the above named provider of information. Any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Disclosed information may be reviewed by contacting the provider of information.

RESTRICTIONS:

The authorization is being given with the understanding that the receiver may not further use or disclose the medical information unless another authorization is obtained from me or unless such use of disclosure is specifically required or permitted by law.

Signature of patient or authorized representative:

_____ Date: __ __/__ __/__ __

Witness_____ Date: __ __/__ __/__ __