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PATIENT AUTHORIZATION FORM FOR RELEASE OF RECORDS

_____ _____/_____/_____
(PATIENT NAME) (DATE OF BIRTH)

I, _____, hereby authorize, _____, to use or disclose the specific information described below, only for the purpose and parties also described below.

Release specific information to: _____
_____
_____

Description of the specific information to be used and disclosed:

__ Entire Medical Records
__ Lab / X-ray / Diagnostics
__ Clinical Notes

Dates of Service: ___/___/_____ to ___/___/_____
(FROM) (TO)

This information is being requested for the following purpose(s):_____

This authorization shall remain in effect from the date signed below until _____

I understand that:

- I may inspect or copy the protected health information to bo used or disclosed
- I may revoke this authorization in writing by contacting your office at the address above.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer to be protected by HIPPA
- I may refuse to sign this authorization (except to the extent that the authorization is for research related treatment in which case you may refuse to provide that research related treatment.

Signature:_____ Date: ____/____/_____

Printed Name: _____