

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Name of Patient _____ Date(s) of Service _____

Date of Birth _____ Social Security Number _____

I, the undersigned, authorize the release of information specified below from the Medical Record(s) of the above-named patient.

PATIENT INFORMATION IS NEEDED FOR:

- Personal Use
- Continuing Medical Care
- Military
- Legal Purposes
- Social Security/Disability
- Other, specify: _____
- Insurance
- School

INFORMATION TO BE RELEASED:

- History & Physical
- Consultation Report
- Emergency Room Record
- Operative Reports
- Dismissal Summary
- Face Sheet
- Lab/Pathology Reports
- X-ray Reports
- Other, specify: _____

The above information may be released to (specify name or title of individual or the name of the organization to which records are to be released and the appropriate address):

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number _____

Address (Street, City, State, Zip Code)

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. I understand I may be charged a retrieval/processing fee and for copies of my medical records according to applicable law.

This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time or unless otherwise specified by date, event, or condition as follows:

Date: _____ Signature: _____
Patient or Legally Authorized Representative.

Relationship to Patient