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	Factel Pharmacy & Physician Report

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: Pharmacy & Physician Report

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

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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:

I understand that I have a right to a copy of this authorization.

I understand that treatment, payment, enrollment, or eligibility for benefits cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes and as otherwise permitted under applicable law.

A photostatic copy of this authorization shall be considered as valid as the original.

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Date:________________________ Signature: ___________________________________

Patient or Legally Authorized Representative.

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Relationship to Patient