



Authorization for Release of Medical Information

Name of Patient: _____ Date of Birth: _____

Address of Patient: _____ SS#: _____

Patient Telephone (Daytime) _____ (Evening) _____

I hereby authorize: _____

To release the information checked off below to: _____

Address: _____

Telephone No.: _____ Fax No.: _____

Medical information covering the period(s) of treatment from: _____ to: _____

Complete Health Record(s)

Progress Notes

Consultation Reports

Laboratory Tests

Radiology Reports

Details: (if necessary) _____

Full Summary

Other: (Please Specify) _____

I understand that this will include information relating to:

AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection or Mental Health unless I request otherwise above.

Purpose for Disclosure: _____

Method of Delivery (check one): Pick Up By Mail By Fax

By signing below, I am requesting access to health information in the manner described above. This information may be redisclosed if the recipient(s) described on this form is not required by law to protect the privacy of the information, and such information is no longer protected by federal health information privacy regulations. I understand that there may be fees for copies, summaries or explanations, that I may be charged for fulfilling this request, and that I will have an opportunity to modify or withdraw my request if I do not want to pay those fees.

I understand that this authorization may be revoked in writing at any time, except to the extent that action has already been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire automatically six months from date on which it is signed. You have a right to refuse to sign this authorization. Your health care, the payment for your health care and your health care benefits will not be affected if you do not sign this form.

Signature of Patient, If Minor, Signature of Parent of Legal Guardian (Relationship)

Date

Signature of Witness

Date

NOTICE TO RECIPIENT: This information has been disclosed to you from records whose confidentiality is protected by State & Federal Law. State & Federal regulations 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 for the release of medical or other information is not sufficient for this purpose.

GENERAL INFORMATION

If your request is relevant to continued care by another physician or hospital, we will be glad to copy the information and forward it (fax) directly to another physician or hospital of your choice.