

Authorization for Release of Medical Information

I, _____, _____/_____/_____, _____
 (Name of patient) (Date of birth) (Phone number)

 (Street Address) (City) (State) (Zip) **authorize**

My records to be released from: _____
 (Name)

 (Street Address) (City) (State) (Zip)

My records to be sent to: _____
 (Name)

 (Street Address) (City) (State) (Zip)

The type of information to be disclosed (check all that apply):

	Visit Date		Visit Date	Initials
_____ All Records	_____	_____ Medication Records	_____	_____
_____ Progress Notes	_____	_____ X-ray, CT, MRI	_____	_____
_____ Discharge Summary	_____	_____ Lab Reports	_____	_____
_____ History and Physical	_____	_____ Pathology Report	_____	_____
_____ Consultation Report	_____	_____ Mental Health	_____	_____
_____ Operative Report	_____	_____ Alcohol/Drug Report	_____	_____
_____ Procedure: _____	_____	_____ Sexually Trans Disease	_____	_____
_____ Other: _____	_____			
_____ HIV (AIDS) Test Results _____	_____			

(Requires your signature here)

The purpose of the disclosure is: (check one)

- Medical Care Payment of Claim/Benefits Personal Use
 Legal Investigation Insurance Application Other (please specify) _____
 I have a claim for Workers' Compensation and I specifically authorize you to engage in verbal communications with the Workers' Compensation insurer about my protected health information.

Permission to Release Records

I understand that I may revoke this authorization by written notification at any time following this date, except for the information that may have been released prior to the revocation. Unless otherwise specified, this consent will expire one year from the signed date. This authorization will be effective for medical records generated to the date of the signature.

I understand that in accordance with State and Federal confidentiality regulations the information disclosed may include reference to or treatment of alcohol/drug abuse, emotional illness, developmental disability, or psychiatric care only if I indicated above with my initials or signature. Further disclosure of this information without written consent is prohibited by law.

I understand that there will be a fee charged to me to cover the cost of copying and sending my records. This fee will be billed by and payable to the copy service that processes my request for copies of my medical records.

Expiration date or condition to expire: 6 MONTHS

 (Signature of person giving consent) (Date signed) (Witness) (Date signed)
 The signature is of the _____ Patient _____ Parent of Minor _____ Legal Guardian
 _____ Patient's Executor or Next of Kin
 _____ Person authorized by Patient _____
 (Specify relationship or authority to act)