AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION (Please Print)

Patient Name: ____ **Date of Birth:** ___________________________

Address: ____

____

Daytime Phone Number:____

I hereby authorize my physician(s) and/or administrative and clinical staff at _______________________________

____

to disclose the protected health information described below to:

Name____ MAIL_______________

Address PICK UP

(A separate form is required for visits with psychiatrists.)

Information to be released:

(**NOTE: A fee may be charged for providing your records.**)

____ Medical records for Past Year* _____ Medical Records for past 2 years*
____ All Medical Records Stored On Site for the past _____Years.*
____ CT images and Report for ____.
____ MRI images and Report for ____.
____ Sono images and report for ____.
____ X-Ray images and report for ____.
____ All Medical Records Stored On Site for the past _____Years.*
____ Archived Records Stored Off Site*
____ ONLY the Information Described as Follows ______________________________________
____

This protected health information is to be disclosed for the following purpose:_____________________________________

IF RECORDS ARE BEING SENT TO ANOTHER DOCTOR OR PROVIDER PLEASE INDICATE REASON: ____Changing Doctor or Provider ____2nd Opinion ___Moving _____ Other ____

***I understand that my records may contain reference to or results of HIV (AIDS) antibody testing, testing or treatment of communicable diseases, treatment for mental health problems, alcohol history, or substance abuse, and I authorize the release of such confidential information to the indicated party, unless specifically prohibited in my instructions above.**

I understand that my physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I provide authorization for a requested disclosure except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Contact of the practice I authorized above to disclose the specified protected health information. I understand that a revocation is not effective to the extent that action has already been taken in reliance on the authorization or during an insurance claim contestability period if my authorization was obtained as a condition of obtaining insurance coverage.

I understand that a photocopy of this authorization shall have the same force and effect as the original authorization.

I understand that information disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by federal or state law.

EXPIRATION DATE: This authorization is valid until _________________________, at which time this authorization to disclose this protected health information will expire. If no expiration date is indicated above, I understand that this authorization will be valid for ninety (90) days from the date signed.

Signature of Patient/ Legal Representative:____ **Date**: ________________________

Relationship to Patient:____

Witness: ____ **Date:** ________________________