

**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 _____

Address or Fax Number _____

Mail: ____ Pickup: ____
Paper: ____ CD: ____ Fax: ____

For your convenience we now generate all requested records in paper format unless requested otherwise.

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

- Information to be released:**
- _____ Medical records for the past year* _____ Medical records for past 2 years*
 - _____ All medical records stored on site for the past _____ years.*
 - _____ CT images and report of/on _____.
 - _____ MRI images and report of/on _____.
 - _____ SONO images and report of/on _____.
 - _____ X-RAY images and report of/on _____.
 - _____ Archived records stored off site*
 - _____ Immunization records
 - _____ Lab work of/on _____.
 - _____ ONLY the information described as follows: _____
- (**NOTE: A fee may be charged for providing your records.**)*

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: _____ Time: _____ Date: _____