Medical Records Release

Patient Name:_____ **DOB**_____

Patient Address:_____

_____ Phone Number:_____

Authorize the Release of Health Information Relating to Me as Described Below:

Provider authorized to release my information:_____

Provider's Address:_____

_____

To Whom My Records May be Provided:

Name of Individual (includes self) or organization receiving information

_____

Address:_____ Phone:_____

_____ Fax:_____

Specific Information to be Released (Copying Fee may be Charged)

☐Entire Record ☐Billing ☐Lab Reports ☐Encounter Notes

☐Other:_____

*Covering the periods of treatment from***:**_____

Purpose/ Use of Released Information

☐Personal Use of Patient ☐Medical Care ☐Social Security ☐Legal Litigation

☐Other:_____

Authorization Expires (Date or Event)

Date from Signature:_____ **OR** Date of following event:_____

IF NO DATE PROVIDED THIS RELEASE EXPIRES 1 YEAR AFTER SIGNATURE

Disclosure Notices:

I understand that information in response to this request may be related to diagnosis or treatment for AIDS/HIV, psychiatric care and treatment, and or treatment for drug and alcohol abuse. Please check the appropriate boxes below.

AIDS/HIV Information	**Psychiatric Care**	**Drug/Alcohol Treatment**
□YES, disclose	□YES, disclose	□YES, disclose
□NO, do not disclose	□NO, do not disclose	□NO, do not disclose

Limitations, Revocation, and Signature

I understand that if the person or entity receiving my individually identifying information is not a health care provider covered by federal privacy regulations, my information my be re-disclosed by the recipient and may no longer be protected by federal or state law.

I understand authorizing the use or disclosure of the information identified above is voluntary. My refusal to sign this form in no way effects my treatment payment or enrollment in health plans or eligibility for benefits. You have requested a service (for example, a physical examination, a letter about your medical problems, or a medical second opinion consultation) solely to provide the health information related to that service to a third party at your request.

I understand that I may revoke this authorization at any time, except to the extent it has been relied upon. I understand that if I revoke this authorization, I must do so in writing and give my written revocation to my physician's office.

Signature of Patient/Patient's Representative:_____

Print Name of Patient/Patient's Representative:_____

Relationship of Representative (parent, guardian, etc.)_____
(Please provide necessary documentation proving your authority)

Notary:_____ **Date:**_____

Revocation Section: To Be Completed and Signed by Patient/Patient's Representative

This consent has been revoked on:_____

Signature of Patient/Patient's Representative:_____

Print Name of Patient/Patient's Representative:_____