AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name:_____ Date of Birth:_____ Social Security Number: _____

Patient Address: _____

I hereby authorize (physician's name):_____

To disclose records obtained in the course of my evaluation and/or treatment to:

_____

Disclosure will include: (check all that apply) ☐ ALL Dates: _____

☐ History & Physical ☐ Lab Reports ☐ Operative Reports ☐ Radiology Reports

☐ Progress/Physician Notes ☐ Pathology Reports ☐ Other: _____

Include the following: (indicate by initialing)

_____ Diagnosis, Evaluation and/or treatment for alcohol and/or drug abuse.

_____ Records of HIV testing and/or AIDS diagnosis or treatment.

_____ Psychiatric, psychological records or evaluation and/or treatment for mental health, physical and/or emotional illness including narrative summary, tests, social work assessment, medication, psychiatric examination, progress notes, consultations, treatment plans, and/or evaluation.

I understand that failure to initial the above three (3) items, indicates that I do not want those specific records released.

I also understand the following:

- I have the right to limit the type of information released. If I choose to limit the information released, I understand it may be necessary for my health care provider to inform the requester that portions of the record have been withheld.
- This authorization shall remain valid unless revoked but will expire 1 year after signing. This consent is subject to written revocation by the undersigned at any time except to the extent that action has already been taken.
- My health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of my health information. I hereby release all parties from any/all legal liability that may arise from the release of this information to the party named above.

_____ _____

Signature of Patient or Substitute Decision Maker Date

_____ _____

If Substitute Decision Maker, state relationship If Substitute Decision Maker, state reason

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REASON FOR REQUEST:
___MOVING OUT OF STATE
___NO INSURANCE
___NEW PATIENT
___PERSONAL RECORDS
___TRANSFERRING CARE
REASON: _____
_____
_____

METHOD OF DISCLOSURE:
___MAIL TO ABOVE PATIENT ADDRESS ___HAND DELIVERED TO PATIENT
___MAIL TO ABOVE PROVIDER ___FAX TO ABOVE PROVIDER

_____ _____

Signature of Completer Date

PATIENT ACKNOWLEDGMENT OF RECEIPT OF HAND DELIVERED RECORDS:

_____ _____

Signature Date