MEDICAL RECORDS RELEASE

Authorization for Release of Confidential Medical Information

Patient Name ________________________________ S.S. # ______________________________________

Date of Birth ______________________________ Patient Phone: _______________________________

Records to be released from ___________________ to ______________________________

(date) (date)

This information is to be: ____________ ***Released TO*** ***or*** _____________ ***Released FROM***

Practice Name: _____________________________ Attn: ______________________________

Address: ___________________________ City, State: _______________________ Zip: ___________

Phone: _____________________________ Fax: ____________________________

Purpose of disclosure (check one): ____ Insurance _____ Personal

____ Legal _____ Continuing Care _____Other (specify): ____________

The information disclosed may be subject to re-disclosure by the recipient and will no longer be protected by the Privacy Protections.

Records Being Requested – Check All That Apply:

____ Office Notes ____ Immunization Records ____ Counseling Records ____ Physical Exam

____ Therapy Records ____ HIV Testing/Information ____ Physician's Orders ____ Radiology

____ Drug/Alcohol Test Results ____ Consultations ____ Mammogram ____ Diagnostic Test

____ Lab Reports ____ Other ___________ _____ ALL RECORDS

I hereby authorize the clinic indicated above to disclose/release medical records and/or other information obtained in the course of my diagnosis and/or treatment. I agree to pay copy charges if applicable for Legal, Insurance and/or Personal Use. I hereby release the clinic indicated above from any liability which may result from this disclosure of confidential medical information, or which may arise as a result of the use of the information contained in the information released. I understand that I may revoke this authorization by providing written notice of by intention. Unless withdrawn, this consent will expire 90 days from the date signed.

____ This information may include Medical/Surgical, Psychiatric, Substance Abuse, HIV/AIDS information

____ I authorize that this information may be FAXED to the requesting Health Care Provider

Patient's Signature __________________________________ Date: ______________________

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