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Authorization to Release Medical Records

Name of Patient ________________________________ Date of Birth ____________________

Date(s) of Service ___________________

I, the undersigned, authorize the release information specified below from the medical record(s) of the above named patient.

INFORMATION TO BE RELEASED OR ACCESSED: (Please circle)

Office notes - Operative Reports - Lab/Path Reports - X-Ray Reports/Images - Audiology Testing/Reports Other:

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The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address):

TO:

____

____(Doctor, Hospital, Attorney, Insurance Company, Self, etc.)   Phone Number

____

____Address (Street, City, State and ZIP)

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. The authorization will expire six (6) months from the date of my signature, unless I revoke the authorization prior to that time.

Signature: ____ Date:__________________
Patient or Legally Authorized Representative

____
Printed Name of Patient or Legally Authorized Representative