Authorization For Use or Disclosure of Medical Record Information

Patient Information

Patient Full Name: _____ Date of Birth: _____

Patient Address: _____ Home Phone: _____

City: _____ State _____ Zip: _____ Work Phone: _____

I hereby Authorize :

Please choose one: ◉ Release my medical record information to ○ Obtain information from

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State _____ Zip: _____ Fax: _____

Purpose of Request: ○ Personal ○ Referral or 2nd Opinion ○ Legal ○ Insurance ○ Other _____

○ Transfer from Practice/Reason? _____

Patient Information to be released:

Dates of Service: From _____ To _____

- ○ ER
- ○ Consult
- ○ Operative Report
- ○ Complete Medical Record
- ○ X-Ray
- ○ Lab
- ○ Discharge Summary
- ○ Other _____
- ○ Abstract
- ○ H & P
- ○ Progress Note

Restricted Authorization to Release Protected Information:

STOP **IMPORTANT -** It is extremely important that you select either you "**DO**" or "**DO NOT**" for each item contained in this section *Authorization to Release Protected Information*. Please do not skip any line item as it could impact our ability to fulfill your request and cause additional delays.

Release Records? Check one

I ☐	**DO**	☐	**DO NOT** want **Mental/Behavior Health or Disability Services Provider Documentation *** released**.**
I ☐	**DO**	☐	**DO NOT** want **HIV/AIDS Screening Test Results** released
I ☐	**DO**	☐	**DO NOT** want information about **Alcohol and/or Substance Abuse Treatment** *** released
I ☐	**DO**	☐	**DO NOT** want **Genetic Testing/Test Results **** released
I ☐	**DO**	☐	**DO NOT** want **Rape/Sexual abuse** released
I ☐	**DO**	☐	**DO NOT** want **Confidential Communications with a Social Worker** released
I ☐	**DO**	☐	**DO NOT** want information about **Rape/Sexual Assult Victim's Counseling** released
I ☐	**DO**	☐	**DO NOT** want **Child/Elder Abuse or Neglect & Abuse of an Adult with a Disability** released
I ☐	**DO**	☐	**DO NOT** want information about **Sexually Transmitted Disease (STD's)** released
I ☐	**DO**	☐	**DO NOT** want information about **Domestic Violence Victim's Counseling** released
I ☐	**DO**	☐	**DO NOT** want information about Abortion released

* This Authorization is not valid for use or disclosure of psychotherapy notes.

** The term "genetic tests" means only those tests which determine your future chances of developing a disease, not test done to diagnose a current condition or problem. This includes information related to the testing of embryo's created during IVF.

*** Only applicable to records that are created by an "individual or entity who holds itself out as providing alcohol or drug abuse diagnosis, treatment or referral for treatment" (42 CFR Part 2). Does not include records created or maintained by a general medical facility.

Sign Here _____ Date Here _____

Signature of Patient's **Date**

Signature of Personal Representative **Date** **Relationship to patient or authority to act for patient**

Term: This Authorization will remain in effect for 12 months from the signature date.

Revocation: I understand that I may revoke this Authorization at any time by requesting it of the health care facility in writing at the address listed below. The revocation will be effective immediately upon receipt of my written notice. I understand that the revocation will not have any effect on any action taken by the health care facility in reliance on this Authorization before it received my written notice of revocation. Written Notice is to be mailed to your the privacy officer at your provider's office.

Effect on Treatment: I understand that I may refuse to sign this Authorization for any reason and that such refusal will not affect the commencement, continuation or quality of my treatment

Potential for Redisclosure: I understand that the person receiving my Protected Health Information may not be required to comply with federal and state Privacy laws, and my Protected Health Information may no longer be protected by the applicable state and federal law once it is disclosed.

Access: I understand that in certain circumstances the health care facility has the right to deny me access to all or portions of my Protected Health Information and must notify me in writing of any such denials.