Optimal Health Medical Institute

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND/OR MEDICAL RECORDS

I (name), _____ (date of birth) _____ hereby authorize that my Protected Health Information be disclosed as described below. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I may see and copy the information described on this form if I ask for it, and that I will receive a copy of this form after I sign it. I understand that I may revoke this authorization at any time by giving notice in writing at the address found above, but if I do it will not affect any actions taken before receipt of my revocation. I understand that my treatment will not be conditioned on whether I provide authorization for the requested use or disclosure except if my treatment is related to research, or healthcare services are provided to me solely.

Release to: _____
(Name, address, phone and fax number)

From: _____
(Name, address, phone and fax number)

Release the following Protected Health Information:

- ☐ Laboratory
- ☐ Progress Notes
- ☐ Operative Reports
- ☐ X-ray Results/Reports
- ☐ Prescription History
- ☐ Billing/Claim Records
- ☐ Bone Density
- ☐ Wellness Exam Results
- ☐ Other (please specify):
- ☐ _____
- ☐ _____

Are you transferring care to another physician/facility? (please circle) YES or NO

This authorization is in full force until _____ or until _____
(Date) (List specific event)

I understand that my health information to be released may include information that is related to sexually transmitted diseases, AIDS, HIV, behavior or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information unless I have crossed it out and initialed it.

Signature of patient: _____ Date: _____
(Form must be completed before signing)
Patient's Guardian/Representative (if applicable): _____

Relationship to the patient: _____

This message is intended for the use of the person or entity to which it is addressed and may contain information that is confidential and privileged, the disclosure of which is governed by applicable law. If you are not the intended recipient, or employee, or agent responsible to deliver it to the intended recipient, you are hereby notified that any disclosure, copying, or distribution of this information is strictly prohibited.