AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the release of information from the medical record of:

Patient Name: ______________________________ Patient Date of Birth: _________

Home phone: ______________________________ Cell phone: _____________

Patient Address: ___________________________City______________ State ____

Information released from:

Name: ____

Address: ____

City/State/Zip: ____

Telephone Number: ____

Fax Number: ____

Information released to:

Name: ____

Address: ____

City/State/Zip: ____

Telephone Number: ____

Fax Number: ____

Please release the following information:

❑ Progress notes ❑ Laboratory Reports ❑ HIV/AIDS Test

❑ Consultations ❑ Imaging Reports ❑ Drug/Alcohol

❑ Immunizations ❑ Sleep Study

❑ EKG Reports ❑ EEG Reports

❑ Other Diagnostic Reports (specify) ____

This information is necessary for the following purpose:

❑ Continued patient care ❑ Personal use ❑ Attorney/Legal

❑ Insurance ❑ Other (Specify)________________________

PLEASE DO NOT LEAVE ANY AREA BLANK

Informed consent for Release of Confidential Information

I understand that:

- I may revoke this consent in writing at any time, except to the extent action has already been taken.
- This consent will expire one year after the date of my signature, unless otherwise specified.
- I understand that there is a **fee** for copy service rendered.
- I understand that the information released is for the specific purpose stated above.
- I understand that this information may include HIV/AIDS, mental health, chemical dependency, sexually transmitted disease diagnosis, treatment and test results.
- I understand that my medical records may contain reports that only a physician can interpret.
- I understand and have been advised that I should contact my physician regarding entries made in my medical record to prevent my misunderstanding of the information contained in these entries.
- I will not hold DICKSON MEDICAL ASSOCIATES liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for correct interpretation.
- I understand that payment of the above fee is due prior to my records release and that **within ten (10) working days of receipt of payment,** my records will be available.

____ _____________________

Signature of Patient Date

____ _____________________

OR Legal Representative Relationship to Patient

____

Witness

For Office Use Only:

Date request completed: _________________________ # of pages copied: ________

Charges: $____________________________________ Processor Initials: ________