Serenity
Health & Wellness

120 Carlanna Lake Rd Suite 102
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Authorization for Release of Medical Information

(Last, First, M.I) ***Patient Name***____	***SSN*** ________-_______-_________ ***DOB***______/______/_______

Release from:	***Release to:***
____	____
(Facility Name)	*(Facility Name)*
____	____
(Phone)	*(Phone)*
____	____
(Fax)	*(Fax)*

Purpose of Release:

□Continuing Medical Care	□Work Comp	□Disability Determination	□ Personal
□Insurance Claim	□Application for Insurance	□Other: ______________________________	

Information to be Released:

Service Dates: From: ___________________________ To: ___________________________ **OR**

□ all future records until this Authorization expires.

□ ALL RECORDS *(history & physical, discharge summary, operative reports, consults, outpatient visit notes, test results, labs, ER notes, provider notes related to specific timeframe)*.

□ Discharge Summary	□ ER Records	□ History & Physical	□ Clinic Visit Notes
□ Psychological Evaluation	□ EKG/Cardiology Reports	□ Immunization Records	□ Other______________________
□Lab / Pathology Reports	□ Radiology Images	□ Radiology reports	□Alcohol/Drug Treatment Records

I AUTHORIZE RELEASE OF ALL ALCOHOL AND / OR DRUG TREATMENT RECORDS THAT ARE PART OF THE RECORDS I SPECIFIED ABOVE UNLESS OTHERWISE INDICATED BELOW:

______Do not release alcohol or drug treatment records protected under federal law.

I may revoke this authorization at any time by sending written notice to the facility/provider releasing records. A revocation is not valid if (1) action was previously taken in reliance on this authorization, or (2) if this authorization was obtained as a condition for obtaining insurance coverage. I authorize the facility/provider to disclose medical information to the party identified in the “Release Information To” section. I understand this may include information regarding mental health, alcohol/drug use, and HIV treatment. I understand that once disclosed, information may be re-disclosed by the recipient and no longer protected. I understand this authorization is voluntary and that I may refuse to sign. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or my eligibility for benefits

Signature *(required)*	**Date Signed** (required)
Relationship, If Not Patient:	