MEDICAL RECORDS RELEASE FORM

I do Hereby consent and authorize

Patient's name_____Medical record number_____

Address street number or RFD_____

city state zip code_____ phone_____

date of birth_____ Social Security number last four digits XXX-XX-_____

Records Requested from

Name of person or facility_____

Practice Address Street number or RFD_____

City state zip code_____ phone_____

Email_____ fax_____

Medical record Information May Be Disclosed To:

Name of person or facility_____

Practice Address Street number or RFD_____

City state zip code_____ phone_____

Email_____ fax_____

Date(s) of Treatment Requested:

_____

Information to be disclosed (check all applicable items to be released):

_____Discharge Summary _____ER Record _____Progress Notes _____Treatment Plans

_____Discharge Instructions _____X-Rays Reports _____Medication Records _____Commitment Papers

_____History and Physical _____Lab Reports _____Doctor's Orders _____HIV Testing

_____Consultations _____EKG/ECG Tests _____Nurse's Notes_____ Operative Report _____Therapy Notes

_____ Other (please specify): _____

Purpose Or Need for the Disclosure Is:

_____Continued Medical Care _____Insurance _____Legal _____Patient's Own Use _____Other_____

Please select how you would like to receive your request. _____Mail to the address above. _____Email _____verbal _____Pick up and practice _____Urgent: fax to number listed above

My refusal to sign this form will not adversely affect my ability to receive health care services, reimbursement for services, and enrollment in a health plan or my eligibility for health care benefits. However, information will not be released to the above-indicated recipient without my signature.

I acknowledge that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal Law.

I have the right to revoke this authorization by written notice to the Healthcare Provider listed above. I understand that actions taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

This authorization expires on: _____ or upon the following event: _____
(Date)

(If no date is specified, this authorization will expire in six months from the date of signature).

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, mental health, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).

Fees: I understand and agree that there may be costs associated with this request in compliance with State copying laws.

_____ _____
(Signature of Patient or Personal Representative*) (Date of Signature)

* If signed by a personal representative, a description of the representative's authority to act is as follows:

_____Parent _____Legal Guardian _____Health Care Power of Attorney

_____Administrator _____Executor of Estate _____Next of Kin _____Beneficiary

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(Office use only.)

1 Date processed. _____ Processed by. _____

2 Stamps additional notes. _____