Medical Records – Release of Information

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AUTHORIZATION TO OBTAIN AND DISCLOSE MEDICAL INFORMATION

Patient Name:______________________ **Date of Birth:** ____________
Street Address:______________________
City/State/Zip______________________ **Phone #:** ____________

☐ **Release Records TO:** ☐ **Obtain Records FROM:** ☐ **Self (address same as above)**

Name ______________________ **Phone #:** ____________
Street Address:______________________
City/State/Zip ______________________ **Fax #:** ____________

Information to be released/obtained:

From & To Dates: ____________

☐ **Pertinent Records (last 2 years default)**
☐ **Lab Report(s)**
☐ **Radiology Report(s)**
☐ **Emergency/Urgent Care Records**
☐ **Other**____________

Please send by Fax or CD/DVD

SPECIALLY PROTECTED RECORDS

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

_______ HIV/AIDS information
_______ Mental health information
_______ Genetic testing information
_______ Drug/alcohol diagnosis, treatment, or referral information

Purpose of Disclosure

☐ Continuing Care ☐ Personal Records ☐ Legal ☐ Insurance ☐ Other____________

Restrictions: I understand that the information released may be subject to re-disclosure by the recipient and may no longer be protected.

Rights: I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I may inspect or copy any information to be used and / or disclosed under this authorization in accordance with organizational policy. I understand that I have the right to revoke this authorization in writing. My revocation will be effective upon receipt, but will not be effective to the extent that this organization has taken action in reliance upon this authorization.

X______________________ ____________ ____________
Patient/Legal Guardian Signature **Date** ***Recognized Representative (attach document)***

Note: This authorization will expire 6 months from date of signing.

(5/13)