# 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:** _____ **Whole Chart** _____

☐ **Chart Notes**

☐ **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)