AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ **DOB:** _____ **Phone:** _____

Address: _____ **City/State/Zip:** _____

Please Note: Copy Fee May Be Charged For Medical Records

I hereby authorize the following Health Care Provider to disclose the protected health information from the medical records of the individual listed above: _____.

(Name of Health Care Provider)

Treatment Dates From _____ **to** _____

Please Disclose the Following Information:

- ☐ Entire Medical Record
- ☐ Billing Record
- ☐ Other_____

The Purpose of the Disclosure is:

- ☐ Medical Care
- ☐ Legal/Insurance
- ☐ Other_____

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

INFORMATION TO BE RELEASED TO:

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

These records will be mailed unless you specify a different means._____.

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when law provides my insurer with the right to contest a claim under my policy.

This authorization will expire on _____. **If I fail to specify an expiration date, this authorization will expire one (1) year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for redisclosure and therefor the information may not be protected by federal confidentiality rules.

Any facsimile, copy, or photocopy of the authorization shall authorize you to release the records requested herein.

By signing this form I am confirming my wishes and understand the terms and conditions of this authorization.

_____ _____

Signature of Patient/ Parent/ Guardian or Authorized Representative **Date**

_____ _____

Printed Name Patient/Parent/Guardian or Authorized Representative **Relationship/ Capacity to patient**