

Authorization for Release of Information

PATIENT NAME: _____

DATE OF BIRTH: _____ LAST _____ FIRST _____ MI _____ MAIDEN OR OTHER NAME _____
 _____ - _____ - _____ SS#: _____ - _____ - _____ MEDICAL RECORD #: _____
 MO DAY YR

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DAY PHONE: _____ EVENING PHONE: _____

I hereby authorize _____ (Print Name of Provider) to release information from my medical record as indicated below to:

NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

INFORMATION TO BE RELEASED:

_____ DATES: _____
 _____ History and physical exam _____
 _____ Progress notes _____
 _____ Lab reports _____
 _____ X-ray reports _____
 _____ Other: _____

I specifically authorize the release of information relating to: _____ Substance abuse (including alcohol/drug abuse) _____ Mental health (including psychotherapy notes) _____ HIV related information (AIDS related testing) X _____ SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

PURPOSE OF DISCLOSURE: ___ Changing physicians ___ Consultation/second opinion ___ Continuing care
 ___ Legal ___ School ___ Insurance ___ Workers Compensation
 ___ Other (please specify): _____

- I understand that this authorization will expire on _____ (Print the Date this Form Expires) days after I have signed the form.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
- I understand that if I am being requested to release this information by _____ (Print Name of Provider) for the purpose of:

- By authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign this form.
 - I understand I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I sign it.
 - I have been informed that _____ (Print Name of Provider) ___ will/ ___ will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
- I understand that in compliance with _____ (Print the State Whose Laws Govern the Provider) statute, I will pay a fee of \$ _____ (Print the Fee Charged). There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment.

 _____ OR _____
 SIGNATURE OF PATIENT DATE PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE
 _____ OR _____
 RECORDS RECEIVED BY DATE RELATIONSHIP TO PATIENT

FOR OFFICE USE ONLY	
DATE REQUEST FILLED: _____	BY: _____
IDENTIFICATION PRESENTED: _____	FEE COLLECTED: \$ _____