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Authorization to Release Medical Records / Information

Physician to **provide** record _____ Fax No. _____

Patient's Name: _____

Social Security #: _____ DOB: _____

Person / facility to receive records: _____ Fax No. _____

Address: _____

City, State, Zip: _____

Release these records: **Initials**

1. Only records generated by this facility (not including records received from other sources) _____
2. Only some portion of records maintained at facility (dates of treatment, etc., specify below) _____
3. All medical records at this facility _____

IF YOU DO NOT WANT CERTAIN PORTIONS OFYOUR MEDICAL RECORDS RELEASED, PLEASE READ THIS SECTION CAREFULLYAND INITIAL THE BOXES FOR INFORMATION YOU DO NOT WANT RELEASED. OTHERWISE, YOUR RECORDS WILL BE RELEASED AS SPECIFIED ABOVE.

I authorize the health care provider to release the information specified to the organization, agency, or individual named on this request with the EXCEPTION of:

Initials

_____ Substance abuse, if any

_____ Psychological or psychiatric conditions, if any

Initials

_____ AIDS/HIV, if any

Other (Please specify) _____

The purpose of this request is: "at the request of the individual."

The covered entity may not condition treatment or payment on whe1her or not the individual signs an authorization. There is the potential that the disclosure of your health information to a non-covered entity pursuant to this authorization may be subject to redisclosure and no longer protected. Expiration or revocation of authorization - I understand that I may revoke this authorization at any time and that unless an earlier date is specified, it will automatically expire 12 months after the date affixed below. Use of copies - A copy of this authorization may be utilized with the same effectiveness as an original.

_____
Patient name (print or type):

_____
Patient's signature

_____
Date

_____
Person authorized to sign for patient

_____
(Print or type name)

_____
Signature

_____
Relationship to patient

_____
Date