AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ DOB: _____

Phone # Home_____ Phone# Work_____

Mailing Address: _____

City: _____ State _____ Zip Code _____

Please Note: **COPY FEE MAY BE CHARGED FOR MEDICAL RECORDS**

Above listed patient, authorizes the following healthcare facility to make record disclosure:

Facility Name_____ Facility Phone # _____

Facility Address_____Facility Fax #_____

City, State, Zip _____

Dates and type of information to disclose:

____2 years prior from last date seen

____ Dates Other: _____

____ Specific Information Requested: _____

Purpose of disclosure is:

____Change of Insurance or Provider

____Continuation of Care

____ Referral ____ Other _____

Restrictions: Only Medical records originated through this facility will be copied. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

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

This information may be disclosed and used by the following individual or organizations:

Release to: _____

Address: _____

City, State, Zip: _____ ____ Mail Records

Fax # _____ Phone # _____ ____ Fax Records

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 HIM 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 otherwise revolve this authorization. The authorization will expire on the following date, event, or condition. _____ if I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing authorization for Release of Medical Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Print Name of Authorized Representative _____

Signature of Authorized person. **X**_____ Date _____

Relationship/Capacity to Patient _____ Phone # of Authorized representative_____