Patient Authorization for Release of Medical Records

Patient Name _____ Date of Birth _____

Address _____

Phone Number _____

I authorize the disclosure and use of health information as described below:
(Patient information and recipient information must be completed)

I. Person/Facility Providing Information

Name _____

Address _____

City, State, Zip Code _____

II. Person/Facility Receiving Information

Name _____

Address _____

City, State, Zip Code _____

III. The purpose for which this information may be disclosed:

O Treatment O Payment O Coordination of Care O Per Patient Request

O Other _____

IV. What information may be disclosed:

O Last two years of records
O Appointment information
O Behavioral (Mental/Chemical) Health
O Lab results from _____ to _____
O X-ray and/or imaging results from _____ to _____
O Consultation reports from (please supply doctor's name) _____
O Other (as described here) _____
O ALL OF THE ABOVE

V. This authorization expires on the following date, event, or condition: _____

(Expires in twelve (12) months from the date, event, or condition unless specified.)

I understand that:

- I may revoke this authorization at any time by notifying, in writing, the facility listed above.
- Revoking this authorization does not apply for information that has already been released under this authorization.
- I have the right to inspect or copy the health information to be disclosed.
- If the disclosed information goes to a health care provider or health plan covered by federal privacy laws, federal privacy laws will protect it.
- Information that goes to other persons or entities may not be protected by state or federal privacy laws and may be re-disclosed.
- I do not have to sign this form. Treatment will still be provided to me if I do not sign this form. Payment for services is not contingent upon me signing this form,
- unless those services are for the sole purpose of creating personal information for a third-party, such as life insurance companies.
- A copy of this release may be used as the original form.

Signature of Patient or Legal Representative _____ Date _____

If signed by legal representative:

Print Name of Representative _____ Relationship to Patient _____

FOR INTERNAL USE ONLY:

Records Completed By _____ Date _____

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