AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ _____
Print Patient's Full Name Date of Birth

_____ _____
Street Address Social Security Number

_____ _____
City/State/Zip Code Home Phone Number

_____Discharge Summary _____Pathology Reports _____Emergency Reports
_____History & Physical _____Laboratory Reports _____Other
_____Progress Notes _____Radiology Reports _____

Please list your preferred method of contact to receive practice notification regarding your health:
____Text message, preferred number:_____
____Email, preferred email:_____
____Voicemail, preferred telephone number: _____

_____I do _____I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

I HEREBY AUTHORIZE THE RELEASE OF RECORDS FROM: _____
_____
_____
_____

PLEASE RELEASE INFORMATION TO: _____
_____
_____
_____

PURPOSE OF DISCLOSURE:
____Referral to Specialist ____Insurance ____Workers Comp ____Change of Doctor/Provider
____Legal Investigation ____Personal ____Continuing Care ____Disability Determination
____Other (please specify) _____

Note: There may be a charge for a personal copy or the permanent transfer of your records as follows: A $10.00 base fee, $0.50 per page for pages 1-50, then $0.25 for any pages over 50.

Please provide the best telephone number in the event we need to contact you (home, work or cell):
(_____)_____-_____.

I hereby authorize disclosure of the health information for the above-named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____
Signature of Individual, Guardian or Legal Representative **Date**