Authorization to Release Medical Information

Patient Name_________________________________ DOB________________ Former Name_________________________

Current Address_____________________________City___________________________State_________Zip_____________

Daytime Phone___________________________ Evening Phone___________________________ SS#__________________

I Authorize the Release of Medical Information *FROM* ☐ ← **OR** → ☐ *I Authorize the Release of Medical Information TO*

(select one)

FROM:

____
Physician/or other third party named

____
Address City, State, Zip

Purpose of Release: check one box

☐ Changing Primary Care Physician/Clinic *
☐ Referral/Consultation *
☐ Insurance **
☐ Legal **
☐ Personal use/other **

* Records sent to outside physicians/clinics are provided as a courtesy.
** Fees may apply: the rate is $25 for the first 10 pages and .25 cents each additional page plus postage.

Return to:

TO:

____
Physician/or other third party named

____
Address City, State, Zip

____
Phone # Fax #

Please send my medical records/films to:

Provider Name _________________________Fax#_______________

Purpose of Release: check one box

☐ Changing Primary Care Physician/Clinic
☐ Referral/Consultation
☐ Other: ____________________________

Return to: Facility who will be providing copies of your records.

INDICATE TYPE OF INFORMATION TO BE RELEASED BELOW

☐ General Medical Records –excluding protected records.
Copies of medical records will be limited to two (2) years of information including progress notes, lab and x-ray reports and immunizations. Please contact the Release of Information office directly if additional information is needed.

-OR-

Specific Information Only:

☐ History and Physical specify date ____
☐ Medications/Therapy
☐ Lab, Pathology, EKG specify type or date ____
☐ X-ray reports
☐ Images type ____________________ date taken ______________ report __________________
☐ Operative report specify type or date ____
☐ Accident or injury dates from ______________________________ to_____________________________
☐ Immunizations only
☐ Billing
☐ Other ____

Protected or Sensitive information: I understand that certain information cannot be released without specific authorization as required by State/Federal law. **BY INITIALING** I authorize the release of the following protected or sensitive information.

_______ **DRUG ABUSE DIAGNOSIS/TREATMENT**
Initial
_______ **ALCOHOLISM DIAGNOSIS/TREATMENT**
Initial
_______ **MENTAL HEALTH/TREATMENT**
Initial

_______ **SEXUALLY TRANSMITTED DISEASES**
Initial
_______ **AIDS/HIV TEST RESULTS INCLUDING RELATED HIGH RISK BEHAVIOR**
Initial
_______ **GENETIC TESTING**
Initial

By signing this form, you are authorizing the use or disclosure of your protected health information as described above. This information may be redisclosed if the recipient is not required by law to protect the privacy of the information.

You have the right to revoke this authorization at any time. If you revoke your authorization, the information described above may no longer be used or disclosed. The request to revoke must be in writing and must be received prior to release of information. Unless otherwise revoked, this authorization will expire 90 days from the date of signing.

You are under no obligation to sign this form, and you may refuse to do so. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization, with the exception of obtaining information in connection with eligibility or enrollment in a health plan.

______________________________ ______________________________ ______________

Signature of Patient or Legally Responsible Person **Relationship to Patient** **Date**