Authorization to Release Medical Records

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Patient Information:

Name (Print)	DOB	SSN
_____	_____	_____

Release information to/from

Name of facility or provider

_____

Address and phone number

Information to be released (check one)

__ The most recent 2 years of pertinent information (chart notes, labs, x-rays and special tests

__ All medical records

__ Specific information (Please specify): _____

_____

Patient authorization

I understand that my records may contain information regarding the diagnosis or treatment of HIV//AIDS, STD's, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

∗Exclude the following information from the records release (please initial)

__ Drug/alchohol abuse/treatment/diagnosis __ STD's

__ HIV/AIDS diagnosis/treatment testing __ Mental illness or psychiatric diagnosis

My Rights

I understand I do not have to sign this authorization in order to obtain health care benefit. I may revoke this authorization in writing. To view the process of revoking this authorization, please read the privacy notice to patients posted in the facility where your information is released. I understand that once the health information has reached the noted recipient, that person or organization may disclose it, at which time it may no longer be protected by privacy laws.

Signature: _____ Date: _____

(patient, guardian, or authorized representative)