AUTHORIZATION TO RELEASE MEDICAL RECORDS

_____ who resides at _____

n the city of _____ in the state of _____ hereby authorize:

Name: _____
(PHYSICIAN, HOSPITAL, CLINIC, LAB, RADIOLOGY CENTER OR OTHER HEALTHCARE PROVIDER)

Address: _____

City, St., Zip: _____

disclose the following specific medical information by ☐ mail or ☐ fax or ☐ e-mail to:

Name: _____

Address: _____

City, St., Zip: _____

ım the Health Records of:

Name: _____
(NAME OF INDIVIDUAL WHOSE HEALTH RECORD IS BEING DISCLOSED)

Address: _____

City, St., Zip: _____

r the purpose of: _____

authorization extends only to those data elements/documents initialed below:

_____ Statements of charges or payments

_____ Records of visits (all visits)

_____ Record of visit for a specific date or dates Specific dates include or are limited to: _____

_____ Copies of records or reports provided to the above named (i.e. hospital, lab, clinic, etc)

_____ Progress Notes

_____ Photographs, videotapes, digital or other images

_____ Discharge Summary

_____ History and Physical Examination

_____ Consultation Reports

_____ All of the above

_____ Other (Must be specific) _____

_____ Mental Health and/or alcohol and drug abuse treatment

_____ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Information

_____ Hepatitis Information

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

2. A photocopy or fax of this authorization is as valid as this original.

3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a one year period from the date it is signed, or sooner if noted below. The revocation must be in writing. A revocation form is available from the receptionist.

4. _____, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ _____

(PATIENT'S NAME PRINTED) DATE

_____ _____

PATIENT'S SIGNATURE (OR GUARDIAN, IF A MINOR) EXPIRATION DATE (IF OTHER THAN ONE YEAR FROM DATE ABOVE)

_____

SOCIAL SECURITY NUMBER (FOR IDENTIFICATION PURPOSES ONLY)

_____ _____

PATIENT'S PERSONAL REPRESENTATIVE DATE

_____

_____