AUTHORIZATION TO RELEASE/DISCLOSE MEDICAL INFORMATION

Patient Name: ______________________________
Date of Birth: __________ SSN#: ______________ Phone: ______________
Street Address: ______________________ City, State, Zip: ______________

I authorize the release of the above-named individual's medical records as directed below:

______________________________ is authorized to make the disclosure.
(Name of Facility, Clinician, Practice making disclosure)

The type of information to be disclosed is as follows: (check the types of records to be released)

☐ Complete Medical Record	☐ Consultation	☐ Radiology Report	Other, please specify:
☐ Discharge Summary	☐ Pathology Report	☐ Laboratory Tests	
☐ Operative Report	☐ EKG	☐ X-Rays	
☐ History and Physical	☐ ER Record	☐ Billing	

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and alcohol or drug abuse.

The information identified above may be used by or disclosed to the following individuals' organization(s):

Facility-Clinician-Person: ______________________________
Address: ______________________ City, State, Zip: ______________
Phone: ______________________ Fax: ______________
Email: ______________________________

I would like my records provided to: ☐ Me ☐ Third Party/Other as listed above
Via (if not marked default is US Mail): ☐ US Mail ☐ Fax ☐ Email
Electronic format: (indicate preference) ☐ CD ☐ USB drive ☐ Other

*By selecting email I understand that any information sent via unencrypted email is not a secure method of transmission and cannot be protected by the provider. I also understand that my patient information could be intercepted and redistributed without my knowledge or permission.

This information for which I am authorizing disclosure will be used for the following purpose:

☐ Personal Use ☐ Continued Care ☐ Legal Purposes ☐ Insurance Purposes ☐ Other:

I understand that I have a right to withdraw this authorization at any time. I understand that if I withdraw this authorization, I must do so in writing and give my written withdrawal to the entity making the disclosure. I understand that stopping this release will not apply to information that has already been released by this authorization. I understand that the withdrawal will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

This authorization will expire __________ (insert date or event). If I fail to specify an expiration date or event, this authorization will expire 90 days from the date it was signed.

I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by the federal privacy laws or regulations.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or obtain a copy of any information used or disclosed under this authorization.

I understand that the entity making the disclosure may be paid for the costs of copying information to be disclosed.

____
Patient OR parent, guardian, authorized representative signature Date

____
Witness Signature Date

FOR OFFICE USE ONLY:

	Verified ID (ex. Copy of driver's license, check signature, etc.)						
	Picked Up (by who):		**Mailed**		**Faxed**		**Other:**
Processed By:				**Date:**			

A copy of the authorization must accompany any disclosed information.