



**PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

**PLEASE PRINT PATIENT INFORMATION**

<b>LAST NAME:</b> _____			<b>FIRST NAME:</b> _____			<b>MIDDLE:</b> _____			
Date of Birth (MM/DD/YYYY): _____				Phone: _____			Email (optional): _____		
Street Address: _____				City & State: _____			Zip Code: _____		

**PLEASE FILL IN INFORMATION AND CHECK ALL BOXES THAT APPLY**

I authorize \_\_\_\_\_ FAX # \_\_\_\_\_ to release my medical information/records as indicated below:

Progress Notes \_\_\_\_\_
  Entire Medical Records \_\_\_\_\_  
 Consultation Reports \_\_\_\_\_
  Medication Records: \_\_\_\_\_  
 Other (Please Specify) \_\_\_\_\_  
 Date(s) of service from: \_\_\_\_\_ Date(s) of service to: \_\_\_\_\_  
 Test Results  Radiology Reports  Laboratory Reports  Pathology Reports  Radiology Images

**Records to be disclosed:**

Include HIV-related information  Include Alcohol and Drug Abuse records  Include Psychiatric Records  Include Genetic Testing

**I authorize the release of the information to:**

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax # \_\_\_\_\_

Healthcare Provider  Insurance Company or Designee  Attorney  Court  
 Law Enforcement  Employer  Other: \_\_\_\_\_

**Reason for Disclosure**  Patient Request  Benefits Application  Other: \_\_\_\_\_

**PLEASE CHECK REQUESTED FORMAT/MODE OF DELIVERY**

PAPER/MAIL  PDF/EMAIL  FAX

This authorization is effective beginning on the date I sign it and valid for one year from this date or until \_\_\_\_\_. It may be revoked at any time by providing a written notice of revocation to the Medical Records Department, except to the extent that the Providers have already taken action in reliance on it. I am aware that my records are confidential under state and federal law and, except in certain limited circumstances, those records may not be disclosed without consent.

I understand that requests for medical record copies are subject to reproduction fees allowed by laws and regulations, and that I will have an opportunity to modify or withdraw my request if I do not want to pay those fees.

I understand that the release of information about my health status, my psychiatric treatment or diagnosis and/or my diagnosis or treatment for drug or alcohol abuse could have adverse consequences for me.

**SPECIFIC UNDERSTANDINGS**

I understand that this consent may include disclosure of Alcohol and Drug Abuse records and/or Psychiatric records and or HIV-related information (indicating that I have had an HIV-related test, or have HIV infection, HIV-related illness or AIDS, or that could indicate that I have been potentially exposed to HIV).

If I am authorizing the release of HIV/AIDS, Alcohol or Drug treatment, or mental health treatment related information the recipient(s) is prohibited from redisclosing the information without my authorization unless permitted to do so under federal and state law. I also have a right to request a list of people who may receive or use my HIV-related information without authorization.

By signing this authorization form, I am authorizing the use or disclosure of my protected health information as described above. This information may be re-disclosed if the recipient(s) as described on this form is not required by law to protect the privacy Patient of the information and such information is no longer protected by federal health information privacy regulations.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Personal Representative (Personal Representative to sign only if patient is a minor or unable to sign on his/her behalf)

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Phone Number \_\_\_\_\_