



## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I authorize the use or disclosure of the above-named individual's health information as described below.

### INFORMATION TO BE RELEASED BY:

\_\_\_\_\_  
Organization/Person Name

Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_

### INFORMATION TO BE RELEASED TO:

\_\_\_\_\_  
Organization/Person Name

Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_

### TYPE OF MEDICAL INFORMATION TO BE DISCLOSED

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Complete Medical Record  | <input type="checkbox"/> List of Allergies            | <input type="checkbox"/> X-ray reports   |
| <input type="checkbox"/> Physician Progress Notes   | <input type="checkbox"/> Problem list                 | <input type="checkbox"/> EKG             |
| <input type="checkbox"/> Immunization Records   | <input type="checkbox"/> Lab Reports                  | <input type="checkbox"/> Medication list |
| <input type="checkbox"/> Consultation Reports   | <input type="checkbox"/> Other (please specify) _____ |  |
| <input type="checkbox"/> My health information relating only to the following treatment/condition _____ |   |  |
| <input type="checkbox"/> My health information only for the following dates: _____                      |   |  |

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It also may include information about behavioral or mental health services, and treatment for alcohol and drug abuse or self-paid services. You are hereby **specifically authorized to release** all information or medical records relating to such diagnosis, testing or treatment, unless specifically excluded below.

I understand I have a right to cancel this authorization at any time. I understand if I wish to withdraw this authorization, I must do so in writing. I must present my written cancellation to the health information management department. I understand the authorization withdrawal will not apply to information that has already been released due to this authorization. I understand the cancellation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise cancelled, this authorization will expire on the following date or event \_\_\_\_\_. If I fail to specify an expiration date or event, this authorization will expire in six months.

I understand authorizing the release of this health information is voluntary. I can refuse to sign this authorization. I do not have to sign this form to receive treatment. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand any disclosure of information carries with it the possibility for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact my physician's office manager. I understand there may be a charge associated with copying my health information.

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Signature of Patient/Legal Representative

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Date