Medical Records Release Authorization

Patient: _____ DOB: _____ Phone: _____

PLEASE **OBTAIN** INFORMATION **FROM**:

_____
Name of Provider/Clinic/Organization

_____
Street Address

_____
City, State, Zip Code

_____
Phone Number

_____
Fax Number

PLEASE **RELEASE** INFORMATION **TO:**

_____
Name of Provider/Clinic/Organization

_____
Street Address

_____
City, State, Zip Code

_____
Phone Number

_____
Fax Number

I authorize the following information to be diclosed(Please indicate all that apply)

Complete Record	Ultrasound/Sonogram Results	STD Testing
Labs Results	Progress Notes	Other

REASON for disclosure of health information: (Please indicate all that apply)

Transferring to a new physician	Personal Use	Dissatisfied
Moving	Insurance	Job/School
Continuing Care	Legal/Attorney	Other

Please initial each item below to indicate your understanding.

____I acknowledge that VA law allows for reasonable copy fees: $10.00 Administration fee, $0.50 per page for the first 50 pages and $0.25 a page thereafter.

____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 may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

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

____I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

____I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

***This authorization will expire on (insert date or event): _____

(If I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.)

_____
PATIENT SIGNATURE (or Signature of Person Completing Form if Not Patient*) DATE

*Relationship to patient: __ Parent __ Legal Guardian __ Other:

_____
SIGNATURE OF WITNESS DATE