



AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ **Date of Birth:** _____ **Phone:** _____

Request release of information FROM:
(Name and Address)

Request release of information TO:
(Name and Address)

For release of medical information for additional minor children (ages 17 and under), list below:
Name(s) Date(s) of Birth

Please release the following information:
(Check all that apply)

Reason for release:
(Check all that apply)

- Any and all medical records (past year)
- Medical records from only the following dates:
From _____ To _____
- Physician Notes
- X-Ray/Diagnostic Reports
- Laboratory Reports
- Medical records relating to a specific injury. Specify type and date of injury:

- Continuing medical care
- Insurance Company
- Attorney request
- Personal
- Other (please specify)

This authorization will remain in effect no longer than one year from the date of signature or until the following date or event: _____

All information regarding chemical dependency, mental health, alcohol abuse, HIV, or sickle cell anemia will be released unless you restrict here by checking the appropriate area and initialing your restrictive action. Please exclude:

- Chemical Dependency Mental Health Alcohol Abuse HIV Sickle Cell Anemia PLEASE INITIAL

I understand this authorization may be revoked by me, in writing, at any time, but would not apply to any information already released in good faith. A request for revocation or questions about disclosures may be sent to the address listed above. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure at which time the information may not be protected by federal privacy rules. I understand authorizing disclosure of my medical information is voluntary. I can refuse to sign this authorization and still be assured treatment, payment, enrollment, or eligibility of benefits. I understand that I may inspect or copy the information to be used or disclosed, as provided in 4.5 CFR 164.524.

Name of Patient or Authorized Representative

Date

Relationship of authorized representative to patient: _____