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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

_____ _____
(Print patients full name) Birth date (Mo./Day/Yr.)

_____ _____
(Street Address) Social Security Number

_____ _____
(City, state, zip code) Home phone number

I, _____, do hereby authorize_____to release:
(Patient's name)

___Office Notes ___Pathology Reports ___ED reports
___H&P, Discharge notes ___Lab Reports ___Other
___OP Notes ___Radiology Reports ___EKG/Cardiac Reports

From the time period of _____to _____

__I do ___I do **NOT** authorize release information related to AIDS or HIV infection, psychiatric care and/or psychological assessment, and treatment for drug and/or alcohol abuse.

INFORMATION RELEASE TO:

_____
Name of Company/Agency/Facility/Person

_____
Street address

_____
City, State, Zip

PURPOSE OF DISCLOSURE:

___Referral to Specialist ___Insurance Application ___Workers Comp ___Change of MD
___Attorney Request ___Disability Determination ___Personal ___Other_____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for _____ from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or entity receiving it and would no longer be protected by federal regulations. I understand that the medical provider to whom this information is furnished may not condition its treatment of me on whether or not I sign this authorization.

_____
Signature of Patient (or responsible party) **Date**

To help us better serve our patients, please explain why you are transferring your records. _____

_____