

Authorization to Release Medical Information

Patient's Name: _____ Date of Birth: _____

Street Address: _____ SS#: _____

City / State / Zip: _____ Phone: _____

PLEASE CHECK ONE:

[] I will come to the hospital with photo ID to PICK UP my medical information.

[] Please SEND my information TO:

LIST DATES of records to be released:

Name of Physician, Hospital, or Other

Street Address

City / State / Zip

Fax Number

Duration: This authorization shall begin immediately and remain in effect until:

(If no date is entered here, authorization will end automatically after one year.)

I AUTHORIZE THE RELEASE OF THE FOLLOWING RECORDS:

Patients must initial if they wish to include the following:

_____ Psychiatric / behavioral health / mental health records

_____ AIDS / HIV-related records

_____ Drug / alcohol / substance-abuse records

Restrictions: I understand that the information released may be subject to re-disclosure by the recipient and may no longer be protected.

Rights: I understand that I may refuse to sign this authorization and that my refusal to sign may not affect my ability to obtain treatment. I may inspect or obtain a copy of any information to be used and/or disclosed under this authorization in accordance with organizational policy. I understand that I have the right to revoke this authorization in writing. My revocation will be effective upon receipt, but will not be effective to the extent that this organization has already taken action in reliance upon this authorization.

Signature: _____ Patient or Legal Representative Date

If signed by other than patient, indicate relationship: _____

Witness (office use only): _____