Name: _____ Date of Birth: _____

MEDICAL RECORDS RELEASE

I hereby authorize the use or disclosure of my Patient Health Information as described below.

Last Name	First Name	MI
Address		
Date of Birth	Last 4 Digits of SSN	

The following individual/organization is authorized to release the requested health information:

Name	
Address	
Phone	Fax

Patient Health Information to be used or disclosed:

❑ Problem List ❑ Medication List ❑ Immunizations ❑ Progress /Nurse's Notes ❑ Lab/Pathology ❑ Radiology
❑ EKG/Cardiac/Pulmonary/Procedure ❑ Correspondence ❑ Hospital ❑ Other: _____

Please indicate the dates of service being requested: (***THREE*** *years of records only)* From _____ To _____

NOTICE: This authorization is for full disclosure of all records, including clinical findings, diagnosis, treatment, assessment, recommendations for further care, names of health care personnel, dates of hospitalization and ambulatory visits, charges. It also includes any information that may be related to drug, alcohol, psychiatric conditions, and/or sexually transmitted disease, including HIV/AIDS information. These records will be disclosed unless you specifically ask us not to disclose it in the "Exclusions" section below.
Exclusions _____

Specific Purpose of Disclosure: (i.e., Medical Review, Legal Review, Insurance Review, Transfer Records, Personal, etc.)

❑ Authorized Representative's Request ❑ Legal/Insurance Review ❑ Disability Determination ❑ Continuing Treatment ❑ Transfer
❑ Other: _____

This information may be released to and used by the following individual/ organization:

Name	
Address	
Phone	Fax

I understand that:

1. I have the right to change my mind. I may revoke this authorization at any time by submitting a written request the Medical Record Department of the above named organization. I understand that revocation will not apply to information that has already been released in response to this authorization.
2. I have the right to inspect a copy of the Patient Health Information being used or disclosed under federal law.
3. I have the right to refuse to sign this authorization. My refusal to sign will not change my ability to get treatment.
4. I have the right to receive a copy of this authorization.
5. If the organization authorized to receive the information is not an insurance company or other healthcare provider, the released information may no longer be protected by federal privacy laws once it is disclosed.

I have read and understand this information and I am the patient or am authorized to act on behalf of the patient.

_____ _____
Signature of Patient or Patient's Authorized Representative Date

If Authorized Representative, please indicate relationship to patient
❑ Parent of Minor ❑ Spouse ❑ Guardian ❑ Executor of Estate ❑ Power of Attorney ❑ Other: _____

This authorization shall remain in effect until revoked by the patient.