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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize _____and its physicians, employees, and agents to release or disclose to the below-named recipient all of my medical records including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, sexually transmitted disease, or HIV/AIDS infection.

Patient Name: _____Date of Birth: _____

I hereby authorize the release of medical records to: _____
_____

Purpose of disclosure: _____

The authorization will expire on: _____
Date or Event may not exceed one year

This request and authorization applies to:

_____ All medical records, unless indicated as an Exception, below.
_____ Health care information relating to the following treatment, condition, or dates of treatment:
_____
_____ Specific records to be released (e.g., labs, imaging reports, other):
_____

EXCEPTION. If you DO NOT WANT certain portions of your medical records released, please initial the box for the information you do not want released.

_____Substance abuse _____ Psychological or psychiatric treatment _____HIV/AIDS/STD

I understand I have a right to revoke (withdraw or cancel) this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization and that any signed copy may be considered as valid as the original. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

Signature of Patient: _____ Date: _____

Name of Personal Representative (if applicable): _____Relationship: _____

Signature of Personal Representative: _____ Date: _____