Axelix Health Consulting, Inc
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AHCI AXELIX HEALTH CONSULTING, INC.

Authorization to Release Medical Records

Patient:_____ Birth Date_____

Social Security No. (if applicable) _____

PHYSICIAN RELEASING RECORDS:

Name_____

Address_____

City_____

Phone (_____)_____

PERSON TO RECEIVE RECORDS:

Name_____

Address_____

City_____

Phone (_____)_____

DATE(S) OF SERVICE: _____

MEDICAL INFORMATION TO BE SENT:

_____ Entire Medical Record, ***INCLUDING*** information related to the treatment for substance abuse or dependency as protected under Title 42, CFR (if any); psychiatric or mental health treatment including progress notes reflecting communications made to a social worker, psychologist or psychiatrist; information related to testing or treatment of sexually transmitted diseases and HIV/AIDS.

_____ Entire Medical Record, ***EXCLUDING*** information related to the treatment for substance abuse or dependency as protected under Title 42, CFR (if any); psychiatric or mental health treatment including progress notes reflecting communications made to a social worker, psychologist or psychiatrist; information related to testing or treatment of sexually transmitted diseases and HIV/AIDS.

_____ **SELECTED PORTIONS OF THE MEDICAL RECORD ONLY:**

☐ History & Physical	☐ Laboratory Reports	☐ Billing Statements
☐ Progress Notes	☐ Radiology Reports	☐ Other, please specify _____
☐ Consults	☐ Discharge Summary	_____

I authorize medical information to be released as indicated above. I understand this release is effective until _____, but that I may revoke my consent at any time by providing written revocation to the above named physician.

_____ _____
Patient, Patient's Legal Guardian, or Personal Representative ***(PRINT Name)*** Date

_____ _____
Patient, Patient's Legal Guardian, or Personal Representative ***(Signature)*** *Relationship to Patient (if applicable)*

_____ _____
Witness ***(Signature)*** Date