AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

Patient above authorizes the following healthcare provider/facility to make record disclosure:

Release From: Name & Address: _____

_____

Type of information to disclose: ☐_____ or / all medical records

Approximate dates of service: _____ Expiration date for this authorization _____

If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.

Release To: Name & Address: _____

_____

Fax: _____ Phone: _____

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing to the releasing facility noted above. I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure. I understand the information in my health record may include information relating to sexually transmitted disease, mental health services, and treatment for alcohol and drug abuse. I understand that fee may be charged for copying medical records.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____

Printed Name of Patient / Parent / Guardian or Authorized Representative* (circle one)

_____ _____

Signature of Patient / Parent / Guardian or Authorized Representative Date

Address of authorized representative: _____

Phone number of authorized person: _____

*Guardian or Authorized Representative must attach documentation of such status.)

Only medical records originated through this healthcare facility will be copied.