## Authorization To Release Medical Records:

**PATIENT INFORMATION:**

Name (print) DOB SSN

_____ _____ _____

**INFORMATION TO BE RELEASED FROM:**

Name of facility or provider

_____

Address

_____

**INFORMATION TO BE SENT TO:**

Name of designated receipient

_____

Address City State Zip

_____ _____ _____ _____

**INFORMATION TO BE RELEASED: (check one)**

_____ The most recent 2 years of pertinent information (chart notes, labs, x-rays and special tests)
_____ All medical records
_____ Specific information (please specify) :

**PURPOSE FOR WHICH THE DISCLOSURE IS BEING MADE: (please check one)**

_____ Attorney _____ Insurance _____ Doctor _____ Personal

**PATIENT AUTHORIZATION :**

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

* EXCLUDE the following information from the records released (please initial)

_____ Drug / Alcohol abuse/treatment & diagnosis _____ Sexually transmitted disease
_____ HIV/AIDS diagnosis/treatment/testing _____ Mental illness or psychiatric diagnosis/treatment

**MY RIGHTS:**

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

Signature: _____ Date: _____

(Patient, guardian*, or Authorized representative*)

**This authorization will expire 90 days from the date signed**
**Possible copying fee required**