AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PATIENT INFORMATION:

NAME_____

ADDRESS_____

CITY / STATE / ZIP _____

PHONE ( ) _____ DATE OF BIRTH _____/_____/_____

I HEREBY AUTHORIZE AND REQUEST : (Where records are currently located)

NAME_____

ADDRESS_____

CITY / STATE / ZIP _____

PHONE ( ) _____ FAX ( ) _____

To disclose / release the following information* (check all applicable):

- □ **All Records**
- □ **Hospital records**
- □ **Pharmacy / prescription records**
- □ **Other (describe specifically)_____**
- □ **Billing records**
- □ **Records From:_____ to:_____**
- □ **Laboratory / pathology records**
- □ **X-ray / radiology records**

*** Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.**

PLEASE SEND THE RECORDS LISTED ABOVE TO: (Where you want records sent)

NAME_____

ADDRESS_____

CITY/ STATE / ZIP _____

PHONE ( ) _____ FAX ( ) _____

I UNDERSTAND THAT THIS AUTHORIZATION BECOMES EFFECTIVE IMMEDIATELY AND WILL REMAIN SO UNTIL REVOKED BY ME IN WRITING.

I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

DATE:_____ SIGNED:_____

WITNESS_____ RELATIONSHIP_____