For Office Use Only: ☐ Faxed _____ ☐ Mailed _____ ☐ Patient pick-up _____

Authorization to Release Medical Information

Date requested: _____ Date needed by: _____

Patient Name: _____ Former name (if any) _____

Address: _____ City/State/Zip _____

Social Security # XXX-XX-_____ Date of Birth _____ Phone # _____

Information to be released from:

I hereby authorize: _____ to release the following medical information contained in the patient's medical record.

Phone # _____ Fax: _____

Information to be released to:

Name of facility: _____

Address: _____ City/State/Zip: _____

Phone # _____ Fax: _____

Type of Information to be released:

Dates of treatment: ☐ All From _____ To _____

General release: ☐ All

☐ Consultation ☐ History & Physical ☐ Progress / Chart Notes
☐ Discharge Summary ☐ MRI disc ☐ X-ray Films/disc
☐ Operative Report ☐ MRI Report ☐ X-ray Report
☐ Other: _____

By signing this form, I give my specific authorization for release of the records as indicated above.

If the information to be released pertains to alcohol or drug abuse, I understand the confidentiality of the information is protected by federal law (42 CFR, Part 2). Furthermore, I understand that my records my contain information regarding the diagnosis of HIV, AIDS, other sexually transmitted disease, drug abuse, alcohol use, mental illness or psychiatric treatment. Prohibition on Redisclosure: this information has been disclosed to you from records whose confidentiality is protected by Federal Regulation (42 CFS Part 2) prohibiting you from making any further disclosure of this information except with the specific written consent to the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is NOT sufficient for this purpose. Federal regulation state that any person who violates any provision of this law shall be fined not more than $500, in case of first offense and not more than $5000 in the case of each subsequent offense.

Patient authorization to release medical information:

Signature of patient or legally responsible party: _____

Relationship to the patient: _____ Date: _____

This authorization to release information expires 90 days from the date it is signed by the patient, unless it is revoked in writing by the patient prior to the date it expires. To be a valid authorization, it must be signed and dated after dates of service for requested information.