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Authorization for Use and Disclosure of Medical Information

This authorization allows the healthcare provider named below to release confidential medical information and records.

I hereby authorize _____
Physician or Healthcare Facility to release the information

To release my medical records to:

_____
Name

_____
Address

_____
City State Zip

_____
Fax

This authorization will expire on: _____
If I fail to specify an expiration date, this authorization will expire twelve (12) months from the date on which it was signed.

Please Check Requested Records:
☐ PROGRESS NOTES
☐ OPERATIVE REPORTS
☐ PATHOLOGY REPORTS
☐ LAB RESULTS
☐ OTHER (PLEASE SPECIFY) _____

☐ **ENTIRE CHART**

Please initial each item below to indicate your understanding.

____ I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

____ I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

____ I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

____ I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

_____ _____
Signature of patient or legal representative Relationship (if other than patient)

_____ _____
Patient's name Date