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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