



Authorization to Release Medical Information and/or Medical Records

I, (name) _____ (date of birth) _____ hereby authorize that my Protected Health Information be disclosed as described below. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I may see and copy the information described on this form if I ask for it, and that I will receive a copy of this form after I sign it. I understand that I may revoke this authorization at any time by giving notice in writing at the address found above, but it I do it will not affect any actions taken before receipt of my revocation.

I understand that my treatment will not be conditioned on whether I provide authorization for the requested use or disclosure except if my treatment is related to research, or healthcare services are provided to me solely.

Release to: _____
(Name, address, phone and fax number)

From: _____
(Name, address, phone and fax number)

Release the following Protected Health Information:

- | | |
|--|--|
| <input type="checkbox"/> Laboratory | <input type="checkbox"/> Mammogram Results |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Bone Density Results |
| <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Wellness Exam Results |
| <input type="checkbox"/> X-ray Results/Reports | <input type="checkbox"/> Other (please specify): |
| <input type="checkbox"/> Prescription History | _____ |
| <input type="checkbox"/> Billing/Claim Records | _____ |

Are you transferring care to another physician/facility? (please circle) YES or NO

This authorization is in full force until _____ or until _____
(Date) (List specific event)

I understand that my health information to be released **may include** information that is related to sexually transmitted diseases, AIDS, HIV, behavior or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information unless I have crossed it out and initialed it.

Signature of Patient: _____ Date: _____
(Form must be completed before signing)

Patient's Guardian/Representative (if applicable): _____

Relationship to the Patient: _____