AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please complete form thoroughly. Your medical records cannot be released until this form is completed, signed by the patient or legal guardian. There may be a processing fee associated with this request.

AS YOU COMPLETE EACH STEP ON THE FORM, PLEASE MAKE A CHECK MARK IN THE BOX PROVIDED AT LEFT.

Step 1 Completed ☐

STEP 1: Information about you: **PLEASE PRINT!!**

PATIENT NAME: _____ DATE OF BIRTH: _____
Last First

ADDRESS: _____
Street City State Zip

PHONE #: _____

Step 2 Completed ☐

STEP 2: Who has the records now? **PLEASE PRINT!!**

I hereby authorize: _____ M.D.

Physician's _____

Address _____

Phone #: _____

Step 3 Completed ☐

STEP 3: To whom do you wish to release your records? **PLEASE PRINT!!**

To release the following information: Please specify:

☐ ALL RECORDS ☐ Transfer ☐ Other _____

☐ Dates of treatment: _____ to _____ OTHER: _____

TO: _____ M.D.

_____

_____

Step 4 Completed ☐

STEP 4: Your signature:

This authorization is valid for 90 days and may be revoked at any time in writing prior to the expiration date. Additional authorization for redisclosure beyond recipient is required.

_____ _____
Witness Signature Patient's Signature

_____ _____
Date Parent/Guardian's Signature

Step 5 Completed ☐

STEP 5: Release for Sensitive Information:

I UNDERSTAND THAT IF MY MEDICAL RECORD CONTAINS INFORMATION IN REFERENCE TO DRUG AND/OR ALCOHOL ABUSE, PSYCHIATRIC, VENEREAL DISEASE, SOCIAL SERVICE, HEPATITIS B TESTING/TREATMENT, AND/OR SENSITIVE INFORMATION. I AGREE TO ITS RELEASE.

_____ _____
Signature of Patient or Legal Guardian Date

Step 6 Completed ☐

STEP 6: Release of HIV Information:

IN ADDITION TO THE ABOVE SIGNATURES, IF YOU WANT YOUR HIV (AIDS) TESTING/TREATMENT RECORDS RELEASED YOU MUST SIGN AND DATE THE LINE BELOW.

I AGREE TO THE RELEASE OF THIS INFORMATION.

_____ _____
Signature of Patient or Legal Guardian Date

REASON FOR TRANSFER: