Release of Medical Information

Patient Name:__________________________ Date of Birth:________________________
Phone: H) __________________________ Phone: W) ____________________________
Address: ____________________________City/State/Zip:_________________________

I understand that: I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that 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. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition:________________.**
If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.
I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.
I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Patient's Signature____ Date ________________

Authorized Representative's Signature_________________________ Date_________________________

Relationship of Authorized Representative____

Requesting records from:

Name of Facility:__________________________________ Address:__________________________

Name of Physician:____

Fax number:____ Phone number:__________________________

Types of records we are requesting

Any and all types of records you have for this patient

Doctor visit notes
Emergency Room notes
Urgent care notes
History and physical
Hospital Progress Notes
Operation or procedure notes
Clinic notes
Pathology reports
Doctors orders
Nurses notes
Discharge Summary
Lab reports
Radiology Reports
Consultations
Other ____________________________

Records within the following dates:

All records for this patient

Records dated between __________________________and ______________________

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

Please send records to:

Attention:__________________________________

At fax number:________________________Or mail to: