

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name: _____

Date of Birth: _____

Social Security Number: _____

Previous Name: _____

Appointment Date: _____

Phone Number: _____

I request and authorize records to be sent

FROM:

Name: _____

Address: _____

City, State, Zip: _____

Phone and/or Fax: _____

TO:

Name: _____

Address: _____

City, State, Zip: _____

Phone and/or Fax: _____

Purpose of release: (Please check one)

☐ Changing Clinic/Physician ☐ Coordination of Care ☐ 2nd Opinion ☐ Other _____

Reason for the Release of Records _____

Type of information to be released:

☐ CHART NOTES ☐ LABORATORY REPORTS ☐ PATHOLOGY REPORTS
☐ HOSPITAL REPORTS ☐ IMAGING REPORTS ☐ OTHER: _____
☐ IMMUNIZATION RECORDS
☐ FOR THE FOLLOWING DATES OF SERVICE: FROM: _____ THROUGH _____

PROTECTED OR SENSITIVE INFORMATION

Some types of information require a specific authorization to be released because of federal or state laws. They are identified below.

☐ _____ HIV test and test results and related information
SIGNATURE OF PATIENT/ PARENT OR GUARDIAN including high risk behavior documentation.

☐ _____ Drug/alcohol diagnosis, treatment or referral information.
SIGNATURE OF PATIENT/ PARENT OR GUARDIAN

☐ _____ Mental Health treatment information.
SIGNATURE OF PATIENT/ PARENT OR GUARDIAN

☐ _____ Genetic testing information.
SIGNATURE OF PATIENT/ PARENT OR GUARDIAN

Permission to fax information: ☐ Yes ☐ No

SPECIFICALLY CONSENT TO THE TRANSMISSION OF MEDICAL RECORDS VIA FACSIMILE (FAX) MACHINE THE UNDERSTANDING THAT THE CONFIDENTIALITY AT THE RECEIVING END CANNOT ALWAYS BE GUARANTEED.

SIGNATURE TO RELEASE THE INFORMATION

SIGNATURE OF PATIENT/ PARENT OR GUARDIAN

RELATIONSHIP

DATE SIGNED

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.