AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Please read all information and instructions before completing and signing the authorization form

Patient's Name_____ Birth date_____
(please print) LAST FIRST MI

Are medical records filed under another name?_____ Phone number_____

INFORMATION TO BE RELEASED ***BY***	INFORMATION TO BE RELEASED ***TO***
REQUEST MUST HAVE COMPLETE ADDRESS OR FAX NUMBER	**REQUEST MUST HAVE COMPLETE ADDRESS OR FAX NUMBER**
_____ Organization/Person Name	_____ Organization/Person Name
_____ Street Address City, State, Zip	_____ Street Address City, State, Zip
_____ Phone Fax	_____ Phone Fax
_____ Email	_____ Email

TYPE OF MEDICAL INFORMATION REQUESTED:

- ❑ Medical Records ❑ Billing Records
- ❑ My health information relating only to the following treatment or condition_____
- ❑ My health information relating only for the following date(s)_____

REASON FOR REQUEST:

❑ Personal ❑ Transfer of Care ❑ Disability ❑ Insurance ❑ Continuing Care

1. I understand that if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected by these regulations.
2. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits.
3. I have the right to revoke this authorization at any time provided I do so in writing, except to the extent that the information has already used or disclosed the information in reliance on this authorization.
4. The information disclosed above may be re-disclosed by the recipient to additional parties and no longer protected for reasons beyond control.

THERE MAY BE A CHARGE FOR COPIES OF YOUR MEDICAL RECORD UNLESS YOUR COPIES ARE BEING SENT TO ANOTHER PHYSICIAN OR HEALTHCARE FACILITY.

This authorization expires_____(date or event). Authorization will expire in 90 days if not otherwise specified.

My signature below indicates that I hereby agree to and authorize the release of patient health information to the above named person or organization.

Patient signature_____ **Date**_____

Parent or Legal Guardian_____ **Date**_____

Relationship to patient, if other than patient_____
(You may be required to provide legal documentation as proof for power of attorney or guardianship)