

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)