

RELEASE OF MEDICAL INFORMATION AUTHORIZATION

All highlighted sections must be filled out completely or release will not be processed.

PATIENT NAME: _____
 LAST FIRST MI MAIDEN OR OTHER NAME(S) USED
ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____
DAY PHONE: _____ **EVENING PHONE:** _____ **DATE OF BIRTH:** ____/____/____ **SS#:** ____-____-____

I hereby authorize the release of information from my medical records as indicated below.

RELEASE INFORMATION FROM:

PROVIDER/FACILITY NAME: _____
ADDRESS: _____
CITY/STATE/ZIP: _____
PHONE: _____ **FAX:** _____

RELEASE INFORMATION TO:

PROVIDER/FACILITY NAME: _____
ADDRESS: _____
CITY/STATE/ZIP: _____
PHONE: _____ **FAX:** _____

INFORMATION TO BE RELEASED:

LAB REPORT	HIV RELATED INFORMATION	PROGRESS NOTES	OTHER: _____
XRAY REPORTS	IMMUNIZATION RECORD	FAMILY PLANNING	DENTAL RECORDS MENTAL HEALTH PAST 2 YEARS

I do not wish to release records containing information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug or alcohol abuse, mental illness or psychiatric treatment, or Family Planning information.

Signature: _____

PURPOSE OF DISCLOSURE: ****NOTE: 100 page max. on incoming faxes.****

CHANGING PHYSICIANS	CONTINUING CARE	INSPECTION	LEGAL	SCHOOL	INSURANCE	CONSULTATION
DISABILITY DETERMINATION	PERSONAL	WORK COMP.	OTHER: _____			

REQUESTED DATES OF INFORMATION: _____ TO _____

**** RECORDS FOR THE LAST 2 YEARS WILL BE RELEASED IF DATES NOT SPECIFIED****

- I may refuse to sign this authorization.
- I may revoke this authorization at any time, except where information has already been released in reliance on my authorization, provided that my revocation is in writing.
- The Health Center may not condition my treatment on my provision of this authorization.
- This authorization is valid for a 365 day period from the date it is signed or sooner if so specified by me, as indicated below.
- A photocopy or fax of this authorization is as valid as the original.
- The Health Center, its directors, officers, employees, agents and volunteers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Legal Representative _____

Date _____

Printed Name _____

Relationship to patient if signed by Legal Representative _____

Delivery Method: Faxed Mailed Pick Up Format: Paper CD

ACKNOWLEDGMENT OF RECEIPT

Patient's Name (Please Print): _____ Signature: _____ Date: _____

Staff Acknowledgment: _____ Date: _____