Authorization to Release Medical Information

This form provides the authorization necessary for the release of your Protected Health Information.

I hereby authorize the release of information from the medical record of:

Name: _____ DOB: _____/_____/_____
Last, First

Telephone #: (_____) _____ SSN: _____-_____-_____

FROM:

_____

_____

_____

TO: Name of Health Care Provider or Institution

_____

_____

_____
Address or Fax

OR

☐ **check here if you will return to pickup records**

Specific description of information:

1. □ Immunization records only
2. □ Only those records regarding treatment for the following medical condition or injury: _____
3. □ Records for the period from _____/_____/_____ to _____/_____/_____ (dates)
4. □ Problem List □ X-Ray/Radiology Reports/Images
   □ Progress Notes □ EKG/Cardiac Reports
   □ History/Physical Exam □ Other Diagnostic Reports (Specify): _____
   □ Medical Clearance □ All Records

Including information (if applicable) pertaining to: □ Mental Health □ Drug/Alcohol □ HIV/AIDS □ Communicable Treatment

- I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.
- I understand that I have the right to 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 care providers named above, except to the extent that the health care providers named above have already taken action based upon my authorizations. Unless otherwise revoked, this authorization will expire 6 months from date of signature.
- A copy of this form is available to me upon my request.
- I understand that any private medical information, including HIV-related information and/or behavioral health documentation may be revealed with this disclosure of health information.
- I understand there may be a charge for medical record photocopying, faxing, or other types of transmission including electronic.

I have read this entire form and all of my questions about this form have been answered. By signing below I acknowledge that I accept all of the above.

_____ Date: _____/_____/_____
Signature of Patient or Legal Representative

_____ _____
Last, First If signed by Legal Representative, Relationship to Patient
Print Name of Patient or Legal Representative

COMPLETE ONLY IF INFORMATION IS TO BE RELASED DIRECTLY TO PATIENT:

I understand t hat my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries.

I will not hold the health care providers named above liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____ Date: _____/_____/_____
Signature of Patient or Legal Representative

_____ _____
Last, First If signed by Legal Representative, Relationship to Patient
Print Name of Patient or Legal Representative