

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

This authorization must be written, dated and signed by the patient or by a person authorized by law to give this authorization.

I authorize _____
Name & Address of Hospital / Health Care Provider

Phone# _____ Fax# _____

to release a copy of the medical information for _____
Name of Patient _____ Date of Birth _____

to _____
Name of Recipient _____ Address _____

Phone# _____ Fax# _____

This information will be used on my behalf for the following purpose (s): _____

By checking the spaces below, I authorize the release of the following medical records, if such records exist:

_____ All hospital records (including nursing records and progress notes)

_____ Transcribed hospital records

_____ Laboratory reports

_____ Pathology reports

_____ Diagnostic imaging reports

_____ Clinician office chart notes

_____ Most recent 5 year history

_____ HIV/AIDS related records

_____ Mental Health Information

_____ Genetic testing information

_____ Drug/Alcohol diagnosis, treatment or referral information

_____ Other: _____

This information 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.

Date

Signature of Patient or person authorized by law