

### Authorization for Release of Information

PATIENT NAME: \_\_\_\_\_  
 LAST FIRST MI MAIDEN OR OTHER NAME  
 DATE OF BIRTH: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ SS#: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ MEDICAL RECORD #: \_\_\_\_\_  
 MO DAY YR  
 ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_ ZIP: \_\_\_\_\_  
 DAY PHONE: \_\_\_\_\_ EVENING PHONE: \_\_\_\_\_

I hereby authorize \_\_\_\_\_ (Print Name of Provider) to release information from my medical record as indicated below to:

NAME: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_ ZIP: \_\_\_\_\_  
 PHONE: \_\_\_\_\_

**INFORMATION TO BE RELEASED:**  
 DATES: \_\_\_\_\_

- History and physical exam \_\_\_\_\_
- Progress notes \_\_\_\_\_
- Lab reports \_\_\_\_\_
- X-ray reports \_\_\_\_\_
- Other: \_\_\_\_\_

I specifically authorize the release of information relating to:

- Substance abuse (including alcohol/drug abuse)
- Mental health (including psychotherapy notes)
- HIV related information (AIDS related testing)
- \_\_\_\_\_

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

- PURPOSE OF DISCLOSURE:**
- Changing physicians
  - Consultation/second opinion
  - Continuing care
  - Legal
  - School
  - Insurance
  - Workers Compensation
  - Other (please specify): \_\_\_\_\_

1. I understand that this authorization will expire on \_\_\_\_\_ (Print the Date this Form Expires) days after I have signed the form.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
4. I understand that if I am being requested to release this information by \_\_\_\_\_ (Print Name of Provider) for the purpose of: \_\_\_\_\_  
 a. By authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign this form.  
 b. I understand I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I sign it.  
 c. I have been informed that \_\_\_\_\_ (Print Name of Provider)  will/  will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
5. I understand that in compliance with \_\_\_\_\_ (Print the State Whose Laws Govern the Provider) statute, I will pay a fee of \$ \_\_\_\_\_ (Print the Fee Charged). There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment.

\_\_\_\_\_  
 SIGNATURE OF PATIENT DATE OR PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE  
 \_\_\_\_\_  
 RECORDS RECEIVED BY DATE RELATIONSHIP TO PATIENT

FOR OFFICE USE ONLY

DATE REQUEST FILLED: \_\_\_\_\_ BY: \_\_\_\_\_  
 IDENTIFICATION PRESENTED: \_\_\_\_\_ FEE COLLECTED: \$ \_\_\_\_\_