AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS

1. Regarding Patient — ***COMPLETE IN FULL (See reverse side for instructions.)***

Name - Last, First, MI		
Street Address		Telephone #
City	State	Zip Code
	Birthdate	

2. Records Released From

Name - (i.e. Health Facility, Physician...)		
Street Address		
City	State	Zip Code
Phone #	Fax #	

3. Records Released To

Name - (i.e. Insurance Co., Lawyer, Physician, Self...)		
Street Address		
City	State	Zip Code
Phone #	Fax #	

4. INFORMATION TO BE RELEASED: (Check all applicable categories)

- ☐ Complete Copy of All Records
- ☐ Lab Reports
- ☐ Allergy Records
- ☐ Telephone/verbal communication
- ☐ Itemization/Coding
- ☐ X-ray Reports/films
- ☐ Counseling & Consultation Visits
- ☐ Immunization Records
- ☐ Clinic records pertaining to outpatient treatment of: (Specify approximate date(s) or condition)____________________
- ☐ Other (Specify)____

FOR THE FOLLOWING DATES:____

please release records pertaining to: (Check applicable conditions)

- ☐ Mental Health
- ☐ Developmental Disabilities
- ☐ Alcohol Treatment/Evaluation
- ☐ Aids/Aids-Related Illness
- ☐ Drug Treatment/Evaluation
- ☐ HIV Test Results

5. PURPOSE OR NEED FOR DISCLOSURE: (Check applicable categories)

- ☐ Further Medical Care
- ☐ Payment of Insurance Claim
- ☐ Application for Insurance
- ☐ Legal Investigation
- ☐ Personal
- ☐ School Disability
- ☐ Academics
- ☐ Other:____

6. This authorization will remain in effect until this request is processed unless you specify this authorization will be effective for an additional time period. Written consent is necessary to revoke this request.

- ☐ Additional time period. Specify: ________________________________ ☐ NONE
- ☐ Include future records generated during the additional time period

7. I authorize release of my medical records in accordance with the specification listed above. I understand that I have a right to inspect and receive a copy of the disclosed material. A photocopy of this consent shall be valid as the original.

8. Signature of patient____ **Date**____________________
(If signed by person other than patient, state relationship and authority to do so.)

9. NOTE TO RECIPIENT OF INFORMATION: This information has been disclosed to you from confidential records which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosure of this information without the specific written consent of the patient or legal representative involved.