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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(All sections must be completed)

Patient Name:_____

Date of Birth:_____ Chart#:_____

I hereby authorize _____

_____

_____

and its physicians, employees and agents to release or disclose to the below named recipient all of my medical records including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, sexually transmitted disease or HIV/AIDS infection

I hereby authorize the release of medical records to:

_____

_____

_____

_____

Purpose of disclosure:_____

This authorization expires _____; or event_____

(If no date is given it will expire at the end of 90 days and may not exceed 1 year)

The request and authorization applies to:

_____ All medical records

_____ Health care information relating to the following treatment, condition, or dates of treatment: _____

_____

_____ Specific records to be released (eg. Labs, imaging reports, other)

_____

_____

If You DO NOT WANT certain portions of your medical records released, please initial the box for the information you do NOT want released.

_____Substance Abuse;_____Psychological or psychiatric treatment;_____HIV/AIDS/STD

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance theron before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

_____

Signature of Patient or Authorized Representative Date Signed

_____

Relationship of Patient