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AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

NAME: _____ DATE OF BIRTH: _____

SSN: _____

I hereby authorize:

Physician/Facility: _____Phone:_____
ADDRESS: _____FAX:_____
_____
_____
CITY: _____STATE: _____ ZIP: _____

To disclose/release information from my / my minor child's medical records to:

Physician/Facility: _____Phone:_____
ADDRESS: _____FAX:_____
_____
_____
CITY: _____STATE: _____ ZIP: _____

This information is needed for the following reason:
_____

The specific information I wish to have released is (included dates of treatment):
Copy of Complete Medical Record or records specific to _____
_____

I understand that this authorization is voluntary. I also understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the federal privacy regulations.

I understand that I may revoke this consent at any time, by submitting such a request in writing, except where information has already been released. This authorization is valid for a sixty(60) day period from the date it is signed.

_____ _____
Signature Date

EXPIRES: _____ WITNESS: _____

This medical record may contain information about drug abuse, alcoholism, alcohol abuse, venereal disease, abortion, or mental health treatment. Separate consent must be given before this information can be released.

☐ I DO consent to have this information disclosed. ☐ I DO NOT consent to this information being disclosed

_____ _____
Signature Date

This medical record may contain information concerning HIV testing and / or AIDS diagnosis.
Separate consent must be given before this information can be disclosed.

☐ I DO consent to have this information disclosed. ☐ I DO NOT consent to this information being disclosed.

_____ _____
Signature Date