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MEDICAL RECORDS RELEASE AUTHORIZATION FORM

Patient Name: ____ **Date of Birth:** ________________________

Phone: ____________________________ **Address:** ____

RELEASE MEDICAL RECORDS FROM:

Name: ____

Address: ______________________________________

City/State/Zip: ________________________________

Phone: ____

Fax: ____

DISCLOSE MEDICAL RECORDS TO:

Name: ____

Address: ______________________________________

City/State/Zip: ________________________________

Phone: ____

Fax: ____

I AM REQUESTING MEDICAL RECORDS FOR DATES: FROM: _______________ **TO:** _______________

REASON FOR REQUEST (PLEASE CHECK ONE):

___ **Transfer to Another Provider** ___ **Legal/Custody Purposes** ___ **Appt with Specialist**

___ **Personal Use** ___ **Insurance Purposes** ___ **Other** ____________________

INFORMATION TO BE RELEASED:

___ **Last Physical & Immunizations** ___ **Immunizations Only** ___ **Lab Results**

___ **Entire Records** ___ **Other Specified Records** __________________________________

REQUEST ELECTRONIC FORMAT/DISC ___________ **REQUEST PAPER FORMAT** ____________

I authorize the release of copies of medical records and/or other information as noted above. If specifically indicated by me above I understand that this may include information concerning the following: psychiatric/psychotherapy records, mental health records, drug and alcohol treatment information, specific confidential HIV-related information, and/or any general physical condition information. I authorize this information be released by routine mail or pick-up. I understand that I may revoke this authorization at any time to the extent that the person who is to make the disclosure has already acted in reliance on this authorization. If not revoked earlier, this consent will remain in effect for thirty (30) days and will only be accepted if completed in its entirety.

____ ______________________

Signature of Patient or Parent/Guardian (if patient is under 18) **Date**

____ ______________________

Print Name of Patient or Parent/Guardian (if patient is under 18) **Relationship to Patient**