Authorization for the Release of Medical Records

Patient Information:		
Name:	DOB:	SSN:
Email:		
Address:		
City:	State:	Zip:
Phone:		

Person/Entity Requesting Information:		
Name:		
Address:		
City:	State:	Zip:
Phone:		
Fax:		

Person/Entity Releasing Information:		
Name:		
Address:		
City:	State:	Zip:
Phone:		
Fax:		

Information To Be Released:

- ❑ All Records
- ❑ Office/Clinic Notes
- ❑ Operative Reports
- ❑ Lab/Pathology Results
- ❑ Radiology Reports
- ❑ Immunization Records
- ❑ Other

If you do not want certain portions of your medical records released, please check the categories listed below you would like excluded.

- ❑ Substance Abuse, if any
- ❑ AIDS/HIV/STDs, if any
- ❑ Psychological/Psychiatric conditions, if any

Purpose of Disclosure:

- ❑ Personal Use
- ❑ Litigation/Legal
- ❑ Insurance
- ❑ Continuation of Care
- ❑ Transfer to New Physician

I hereby authorize the release or disclosure all medical records requested to the person(s) or organization listed above, including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, or HIV infection, unless otherwise noted. The authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification cancellation. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the recipient on this request and will no longer be protected by federal regulations. I understand I can refuseto sign this authorization and my healthcare provider may not condition treatment on my signing this authorization.

Patient/Guardian Signature: ____________________________________ Date: _____________