AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use / disclosure of my health information as described below. I understand that any and all records, whether written, oral or in electronic format are confidential and cannot be disclosed without my prior written authorization except as otherwise provided by law.

Patient Name:____DOB:__________________

RECORDS FROM:

____

____

____

Phone #______________________________- Fax#______________________________

SEND RECORDS TO:

____

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Phone #______________________________- Fax#______________________________

Request Medical Information:

_____ Entire Medical Record

Or:

Specific: (Include Date(s) of Service:____)

____ Consultation Reports ____Progress Notes ____ Operative Reports

____Lab Reports (Includes HIV / AIDS info) ____ MRI / CT Scan / Xray ____ Ultrasound Reports

____ Pregnancy Records EDC: ____________________ ____ PAP Smear Reports

The requested information will be used for the following purpose(s):

___ Personal Records ___Disability Determination

___ Insurance Claim ___ Attorney / Legal

___ Transferring care to another provider (Please indicate reason below):

___ Change in Insurance ___Moving out of the area ___Personal reasons

I understand I may revoke this authorization at any time by notifying the Health Information Management Department in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. This authorization expires:________________

I understand that if my protected health information is disclosed to someone who is not required to comply with the Federal Privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

____ ____________________

Signature of Patient Date

____ ______________________________

Printed Name of Patient's Representative (if applicable) Relationship to Patient