RELEASE OF MEDICAL RECORDS AUTHORIZATION

Patient Name: ______________________________ *Date of Birth:* ____________

I. I authorize ______________________________ (healthcare provider) to use and disclose the protected health information described below **to** ______________________________________

______________________________ (individual/practice seeking the information)

Address: ____

Phone Number: ______________________ Fax Number: _____________________

II. This authorization for release of information covers the period of healthcare from:

A. □ _________ to _________ **OR** B. □ all past, present, and future periods.

III. A . □ I authorize the release of my **complete** health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

B. □ I authorize the release of my complete health record with the **exception** of the following information:

□ Mental health records

□ Communicable diseases (including HIV and AIDS)

□ Alcohol/drug abuse treatment

□ Other (please specify): ______________________________________

C. □ Specify Medical Record Requested: ______________________________

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect **until** ______________ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

__________ ________________________ ______________________________

Today's Date *Signature of patient or personal representative* *Printed name of patient/ personal representative **and** relationship to patient*

__________ ________________________ ______________________________

Today's Date *Signature of Witness* *Printed name of Witness*

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