Authorization to Release Medical Records/Information

Physician or facility to provide records: ______________________________

Patient's name: ______________________________

Social Security #: ______________________ DOB: ______________

Person to receive records (name and address):

____

____

I authorize the health care provider to release the information specified below to the organization, agency, or individual named on this request. I specifically authorize the release of information regarding the following condition(s):

<u>Initials</u> <u>Initials</u>

_____ Drug abuse if any _____ Substance abuse if any

_____ Psychological or psychiatric conditions if any _____ AIDS/HIV if any

Release these records: <u>Initials</u>

1. Only records generated by this facility (not including records received from other sources) .... ______
2. Only some portion of records maintained at facility (specify below) .... ______
3. All medical records at this facility .... ______

____

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____

Expiration or revocation of authorization -- I understand that I may revoke this authorization at any time.
Use of copies -- A copy of this authorization may be utilized with the same effectiveness as an original.

Patient name (print): ______________________

Patient's signature: ______________________

Date: ______________________

Person authorized to sign for patient: (print or type) ______________________

Signature: ______________________

Relationship to patient: ______________________

Date: ______________________