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Authorization to Release Medical Records/ Information

From:_____

Patient's Name:_____

Social Security #:_____

DOB:_____

To:_____

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):

Initials
_____Drug abuse if any

_____Psychological or psychiatric conditions if any

Initials
_____Substance abuse if any

_____AIDS/HIV if any

_____

Release these records:
1. Only records generated by this facility (not including records received from other sources)…_☐_____

2. Only some portion of records maintained at this facility (specify below)….....☐_____

3. All medical records at this facility from all sources.…….....☐_____

_____

Expiration of 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.

I hereby authorize the use or disclosure of the health information described in this authorization. I understand that if anyone who receives my health information is not a health care provider or a health plan, my health information my not be protected by federal laws if my health information is redisclosed by that recipient, person or Physician's office.

_____
Patient Name (please print):

_____
Person authorized to sign for patient (please print)

_____
Patient Signature

_____
Authorized Signature

Relationship to patient:_____

Date:_____

Date:_____