



AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Please read all information and instructions before completing and signing the authorization form

Patient's Name _____ Birth date _____
(please print) LAST FIRST MI

Are medical records filed under another name? _____ Phone number _____

INFORMATION TO BE RELEASED BY	INFORMATION TO BE RELEASED TO
REQUEST MUST HAVE COMPLETE ADDRESS OR FAX NUMBER	REQUEST MUST HAVE COMPLETE ADDRESS OR FAX NUMBER
_____ Organization/Person Name	_____ Organization/Person Name
_____ Street Address	_____ Street Address
_____ City, State, Zip	_____ City, State, Zip
_____ Phone	_____ Phone
_____ Fax	_____ Fax
_____ Email	_____ Email

TYPE OF MEDICAL INFORMATION REQUESTED:

- All Records Billing Records Other _____
- My health information relating only to the following treatment or condition _____
- My health information relating only for the following date(s) _____

REASON FOR REQUEST:

- Personal Transfer of Care Disability Insurance Legal Review Continuing Care
- Other (please explain): _____

1. I understand that if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected by these regulations.
2. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits)
3. You have the right to revoke or cancel this authorization, in writing, at any time.

THERE MAY BE A CHARGE FOR COPIES OF YOUR MEDICAL RECORD UNLESS YOUR COPIES ARE BEING SENT TO ANOTHER PHYSICIAN OR HEALTHCARE FACILITY.

This authorization expires _____ (date or event). Authorization will expire in 90 days if not otherwise specified.

My signature below indicates that I hereby agree to and authorize the release of patient health information to the above named person or organization.

Patient signature _____ Date _____

Parent or Legal Guardian _____ Date _____

Relationship to patient, if other than patient _____
(You may be required to provide legal documentation as proof for power of attorney or guardianship)