AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____
First M.I. Last
Address:_____

Patient Birthdate: SS Number Phone( )_____

Please **OBTAIN** information **FROM** the following:

_____
Name of Physician

_____
Name of Clinic/Hospital

_____
Street Address

_____
City/State/Zip

Please **SEND** My Medical Information **TO**:

_____
Name of Person to receive information

_____
Street Address

_____
City/State/Zip

I authorize the above named facility to release the following information:
Purpose or
Need for Data:

By initialing the spaces below, I specifically authorize the release of the following records, if records exist.

_____Please send entire medical record (all information) to the above named recipient. The above named recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record.

_____ All hospital records(including nursing records and progress notes)

_____Transcribed records needed for continuity of care

_____Most recent five year history

_____Pathology reports

_____Radiology/imaging reports

_____*HIV/AIDS related records

_____*Mental Health information
*Must be initialed to be included in other documents

_____**Drug/alcohol diagnostics, treatment or referral information

_____Chart notes

_____Lab results

_____Dental records

____Other_____

_____*Genetic testing information

**Federal Regulation 42 CFR Part 2 requires a description of how much and what kind of information will be disclosed.

_____This authorization is limited to the following treatment:_____

_____This authorization is limited to the following time period:_____

_____This authorization is limited to a worker's compensation claim for injuries of:_____(date).

Consent may be revoked at any time. The only exception is when action has already occurred as instructed in the consent. Unless revoked earlier, this consent will expire in 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

_____
Date Consent Given

_____
Witness

_____
Patient/Parent or Legal Guardian

_____
Physician's Approval

5/11/11