Authorization To Release Medical Information

RE: _____ _____

Last Name First Name Middle Initial Date of Birth

_____ _____

Maiden Name Husband's Name Street, City & State

I hereby authorize: To release to:

_____ _____

Name Name

_____ _____

Address Address

Special Instructions: (e.g. appointment date or pick-up date/time)

_____

_____

Check Reason for Release of Records:

☐ Transfer of Care ☐ Attorney ☐ Second Opinion
☐ Insurance Company ☐ Disability Claim ☐ Social Services
☐ Other (please specify) _____

The specific information to be disclosed is as listed below:

Medical Care from _____ to _____

☐ Complete Record ☐ X-ray reports ☐ Physician notes
☐ Laboratory reports ☐ X-ray films ☐ Other

The information disclosed may include matters regarding mental health, developmental disability, alcohol or drug abuse and infectious diseases, including Acquired Immune Deficiency Syndrome (AIDS) /HIV test results. Refusal to consent to release of information will result in such confidential records not being released. If you do not wish such information to be release, state information to be excluded.

I understand that this consent is revocable at any time PRIOR to the release of this information. This authorization will expire 120 days from the date below. I understand that I retain to inspect and copy the information to be disclosed upon written request.

If consenting party is other than patient: _____
Signature and Relationship

_____ _____

SIGNATURE DATE

_____ _____

WITNESS SIGNATURE DATE

* * * * * * * * * * * * * * * * * * * *

FOR OFFICE USE ONLY:

Record #:_____ Date Received:_____ Date Sent:_____ Initials:_____