Authorization For Release of Medical Records

Last Name: _____ First:_____ Middle: _____
Date of Birth: _____ Social Security Number: _____
Address: _____ City: _____ State: _____
Home Phone: __(_____)_____ Work Phone: __(_____)_____
Company Name: _____

I hereby request access to the protected health information in my health record, from:
(date)_____ to (date)_____ maintained or created by the provider named below to the recipient named below.

□ Pap Smear/Biopsy Results
□ Operative Reports
□ Prenatal Records
□ History/Physical Exam
□ Lab/Pathology
□ Consultation
□ All Records
□ Other _____

□ I will pick up copies of my records □ Electronically send copies of my records to the individual noted below

Records From:	Records To:
Name:	Name:
Address:	Address:
Phone:	Phone:
Fax:	Fax:

Purpose of Request: □ Patient's Request □ Referral □ Other: _____

I understand:

- I may revoke this Authorization at any time by providing my written revocation to the address at the bottom of this form. My revocation will not apply to information already retained, used, or disclosed in response to this Authorization. Unless sooner revoked, the automatic expiration date of this Authorization will be six (6) months from the date of the signature.
- Information used or disclosed under the Authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.
- **THIS INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS THAT MAY INDICATE THE PRESENCE OF A COMMUNICABLE DISEASE OR NONCOMMINCABLE DISEASE. WHICH MAY INCLUDE, BUT IS NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA AND HUMAN IMMUNODEFICIENCY VIRUS ALSO KNOWN AS ACQUIRED IMMUNE DEFICINCY SYNDROME (AIDS).**
- *The information authorized for release may include protected health information related to mental health. Release of mental health records or psychotherapy notes may require consent of the treating provider or a court date.
- The information authorized for release may include drug/alcohol abuse treatment records. This category of medical information/records is protected by Federal confidentiality rules (4CRF Part 2). The Federal rules prohibit anyone receiving this information or record from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. As a result, by signing below, I specifically authorize any such records included in my health information to be released.
- I waive all rights and privileges allowed by law relating to disclosure of confidential information and release the facility its agents and employees from legal responsibility arising from the release of this information.

_____ _____
Signature of Patient or Representative if a Minor Date

_____
Relationship to Patient