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AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ Date of Birth _____

Address: _____

City/State/Zip: _____ Telephone _____

I authorize the release of medical information as indicated below:

FROM: _____ TO: Doctor _____

Practice Name: _____ Name: _____

Address: _____ Address: _____

I would like to pick up my records: please call me at _____ I would like to records mailed (please indicate address above)

What to Release: Please choose the records you would like released:

- | | |
|--|--|
| <input type="checkbox"/> Outpatient notes | <input type="checkbox"/> Laboratory reports |
| <input type="checkbox"/> X-Ray report(s) | <input type="checkbox"/> X-ray Film(s) |
| <input type="checkbox"/> Pathology Report(s) | <input type="checkbox"/> Immunization record |
| <input type="checkbox"/> Other Specify _____ | <input type="checkbox"/> All medical records |

NOTE: The records listed below have special protection by laws. I authorize the release of information pertaining to:

- | | |
|--|---|
| The diagnosis or treatment of AIDS, including results of HIV tests | <input type="checkbox"/> Yes <input type="checkbox"/> No/NA |
| The diagnosis or treatment of drug and/or alcohol abuse | <input type="checkbox"/> Yes <input type="checkbox"/> No/NA |
| The treatment and/or consultation for mental health or psychiatric disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No/NA |

Purpose of the release: Please indicate the reason for this release

- | | |
|---|---|
| <input type="checkbox"/> For another doctor | <input type="checkbox"/> To obtain disability |
| <input type="checkbox"/> Use in a lawsuit | <input type="checkbox"/> Worker's care |
| <input type="checkbox"/> Follow-up related to an injury | <input type="checkbox"/> Armed forces requirement |
| <input type="checkbox"/> Personal use | <input type="checkbox"/> Other _____ |

Expiration date: This authorization will expire in sixty days unless otherwise indicated below:

Please change the expiration date to last for _____ days.

I understand this Authorization can be revoked at any time according the Úæ\, [[áÁúãæããÖ! [~] privacy practices. This request must be made in writing and sent to the same place as the original request. Attach a copy of this release if possible. Treatment, payment, enrollment in any health plan is not conditioned on signing this authorization.

Once these records are released, the information is not protected by Úæ\, [[áÁúãæããÖ! [~] and may potentially be re-disclosed by the party who received these records. Úæ\, [[áÁúãæããÖ! [~], its employees and officers, and attending physicians are released for legal responsibility or liability for release of the above information to the extent indicated and authorized.

I have read and understand this information. I have received a copy of this form and I am the patient or am authorized to act on behalf of the patient to sign this document verifying authorization for the use or disclosure of the protected health information under the above stated terms.

Signature of the patient

Date

Signature of legal representative and relationship to patient

Date

Signature of witness

Date