AUTHORIZATION TO RELEASE MEDICAL RECORDS

Name of patient_____ Date(s) of service_____

Date of Birth:_____ Social Security Number: _____

I, the undersigned, authorize the release of, or request access to the information specified below from the medical records(s) of the above named patient.

1. PATIENT INFORMATION IS NEEDED FOR:

2.	Continuing Medical Care	Military	Social Security/Disability
3.	Insurance	Personal Use	Other:_____
4.	Legal Purposes	School	_____

5. INFORMATION TO BE RELEASED OR ACCESSED:

6.	History & Physical	Consultation Report	Emergency Room Record
7.	Operative Reports	Discharge/Death Summary	Face Sheet
8.	Lab/Path Reports	X-ray Reports/Images	Other:_____

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address):

TO:

_____

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

_____

Address (Street, City, State, and ZIP)

FROM:

_____

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

_____

Address (Street, City, State, and ZIP)

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action ahs been taken in reliance upon the authorization.

Date: _____ Signature: _____

Patient or Legally Authorized Representative

_____

Printed Name of Patient or Legally Authorized Representative

_____

Relationship to Patient