AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Patient: _____ SSN#: _____-_____-_____
Date of Birth: _____ /_____ /_____ Telephone: _____
Current Address: _____
City: _____ State: _____ Zip: _____

List all other facilities/entities records are to be released from:

□ _____ □ _____
□ _____ □ _____
□ _____ □ _____
□ _____ □ _____

I hereby authorize the above listed facility/entity to release the health information indicated below that is contained in my patient records to the Recipient named below. I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse and or HIV/AIDS test results or diagnoses.

Name of Recipient: _____ Telephone: _____
(please print)

Street: _____

City: _____ State: _____ Zip: _____

Reason for Disclosure: _____
(Reason for disclosure must be completed prior to processing.)

Past Dates of Treatment: _____

□ Office Visits	□ History & Physical	□ Physical/Occupational Therapy Reports
□ Emergency Department Reports	□ Cardiac Reports	□ Other _____
□ Discharge Summary	□ Laboratory Reports	□ Other _____
□ Operative Reports	□ Radiology Reports	□ Other _____

This consent is subject to revocation at any time except to the extent the action has been taken thereon. **This authorization and consent will expire one year from the date of authorization written below**. I understand that the recipient of my health information may be charged for the service of releasing medical information. Your health care (or payment for care) will not be affected by whether or not you sign this authorization. Once your health care information is released, redisclosure of your health care information by the recipient may no longer be protected by law.

_____ _____ ____/____ /_____
Signature of Patient/Patient's Personal Representative** Printed Name Date Signed

_____
Relationship, if not Patient

**If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative MUST accompany the request (i.e. court appointed guardian, durable power of attorney for health care). Exception: parent signing for a patient under the age of eighteen.

** For a deceased patient, a court entry or order appointing a fiduciary, executor, or administrator, or letters of appointment received from Probate Court must accompany an authorization signed by the named individual. If the estate has not been probated, a death certificate is required coupled with the documents naming the administrator or executor of the estate.

PLEASE SEND THE LAST TWO YEARS OF COMPLETE MEDICAL RECORDS