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Authorization for Release of Information

Patient Name: _____ Date of Birth: _____

Last 4 Digits of SSN: _____ Phone #: _____

NOTE: All items, 1 through 5 must be completed, along with signature and date.

1.) Release Records To: (Where do you want the information sent? Who may have the information?)	Name of individual, healthcare provider/practice: _____ Address: _____ City: _____ State: _____ Zip: _____ Day Phone Number: _____ Fax Number: _____
2.) Release Instructions: (How do you want the information?)	Release Method / Format Requested: (check one) □ Mail □ Fax (To healthcare provider ONLY) □ Other _____
3.) Purpose of Release: (Why is it needed?)	□ Continuing Care □ Legal □ Patient Request □ Insurance □ Other _____
4.) Treatment Date(s): (When were you seen?)	□ Treatment dates from _____ to _____ (please be specific) OR □ All Treatment Dates
5.) Information to be Released: (What do you want sent or released? Check the appropriate box.)	□ Physician Progress / Visit Notes □ Demographics □ Pathology Report(s) □ Lab Results □ Other _____ _____

I understand this information may include reference to psychiatric / psychological care, sexual assault, drug abuse, alcohol abuse, And/or results of test for all infectious diseases including HIV / AIDS.

I understand that I have the right to cancel / revoke this authorization at any time. I understand that if I cancel / revoke this authorization I must do so in writing and present my written cancellation / revocation to the Medical Records Department. I understand that the cancellation / revocation will not apply to information that has already been released in response to this authorization, as stated in the Notice of Privacy Practice. Unless otherwise canceled / revoked, this authorization will expire / end one year from the date below.

Proof of identity may be required. (Note: Allow 30 days for processing according to Federal Regulations.)

_____ _____
Printed Name of Patient or Legal Guardian / Representative Date

_____ _____
Signature of Patient or Legal Guardian / Representative Relationship to Patient

_____
Signature of Witness