

# Medical Record Release Authorization

Patient Name \_\_\_\_\_ Maiden Name \_\_\_\_\_ SS# \_\_\_\_\_

Date of Birth \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell/Work \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Email Address: \_\_\_\_\_

### A) I hereby authorize records FROM:

Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone# \_\_\_\_\_ Fax# \_\_\_\_\_

### B) To be released TO:

Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone# \_\_\_\_\_ FAX# \_\_\_\_\_

### C) For the purpose of:

- |   |   |
|---|---|
| _____ Litigation                                  | _____ Disability                                |
| _____ Insurance                                   | _____ Work Comp                                 |
| _____ Self/Personal Copy                          | _____ Other                                     |
| _____ Continuity of Care<br>(Temporarily Leaving) | _____ Transfer of Care<br>(Permanently Leaving) |

Date Range _____ to _____	
<input type="checkbox"/> Physician Office Notes	<input type="checkbox"/> Cardiology/EKG Reports
<input type="checkbox"/> Immunizations	<input type="checkbox"/> Lab/Path Reports
<input type="checkbox"/> Operative/Procedure Reports	<input type="checkbox"/> Radiology/XRay/MRI Reports
<input type="checkbox"/> Other _____	<input type="checkbox"/> Minimum Necessary

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to assure treatment. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

**I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.**

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Patient/Parent/Guardian or Authorized Representative)

This authorization will expire one year from the above date unless I specify an expiration date: \_\_\_\_\_  
(Expiration date of authorization)