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AUTHORIZATION TO REQUEST/RELEASE MEDICAL INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: _____

TO: Name of doctor or facility _____

Phone/Address _____

RELEASE TO: Name of doctor or facility _____

Phone/Address _____

I request and authorize the above-named doctor or health care provider to release the information specified below to the organization, agency or individual named on this request.

INFORMATION REQUESTED:

[ ] Copy of history & physical, and discharge summary
[ ] Copy of complete medical record
[ ] Verbal communication about diagnosis & treatment
[ ] Copy of outpatient records
[ ] Other (specify) _____

PURPOSE:

[ ] Continuity of care
[ ] Insurance
[ ] Legal
[ ] Other _____

EXPIRATION:

This release will expire in [ ] 180 days [ ] 360 days [ ] other (specify) _____

I understand that the information released may include information about psychiatric conditions, alcohol and/or drug abuse, and/or HIV status. (Cross out any for which authorization is not given.)

I understand that I may revoke this authorization in writing at any time.

I hereby release the health care provider from any liability which may result from furnishing the information requested. Redisclosure of my medical records by those receiving the above-authorized information may not be accomplished without my further written consent.

Signature of Patient: _____

Date: _____