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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Date of Request_____ Reason for Release_____

Patient Name Date of Birth Phone Number

Address

This authorizes _____to provide a copy, summary, or narrative of my medical Records as indicated by the checkmark(s) below, or otherwise release confidential information.

Please list what medical information you would like to be released.

☐ All records (dates)_____ ☐ X-Rays ☐ Labs

☐ Office Notes ☐ Hospital Records ☐ Other_____

Please release my medical records to:

Facility Name or Person

Address City State Zip

This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand 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 understand once the information below is released it may be re-disclosed by the person or facility receiving it, and would then no longer be protected by federal privacy laws and regulations. I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I understand that in accordance with HIPAA Privacy Rule 45 CFR 164.524 a flat fee of $6.50, inclusive of all labor, supplies and applicable postage will be charged for paper or electronic copies of PHI.

Signature of Patient or Legal Guardian Signature of Witness

Date Date