AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Specified medical information is being requested for:

_____ _____ _____/_____/_____
Last Name MI First Name Maiden/Other Name Date of Birth

_____ _____
Phone# Address City State Zip

Date(s) of service requested: _____/_____/_____ _____/_____/_____
From To

Purpose for release of this medical information: (***Required)***

☐ Continuation of Care ☐ Personal Reasons ☐ Insurance/Disability ☐ Legal Other:_____

Release the medical information from: Disclose the medical information to:

Name:_____ Name:_____

Address:_____ Address:_____

_____ _____

Requested medical information authorized to be released: (check items authorized to be released)

☐ Emergency Records	☐ Pathology Reports	☐ Physician Office Records	☐ Psychological Testing
☐ History & Physical	☐ Lab Reports	☐ Medical Progress Notes	☐ Psychological Progress Notes
☐ Operation Notes	☐ Cardiac Testing	☐ Cardiac Procedure Notes	☐ Psychological Assessment
☐ Radiology Reports	☐ Radiology Films	☐ Physical Therapy Notes	☐ Speech Therapy Notes

Other:_____

Note: While every attempt will be made to protect the privacy of your medical information, please note that release of your medical information to an authorized person or organization could be the subject of re-disclosure by the recipient and therefore no longer protected by the Health Insurance Portability and Accountability Act ("HIPAA") or other federal or state laws. This authorization will expire within 90 days unless you specify otherwise.

_____ _____ _____/_____/_____
Signature of Requestor Relationship to Patient Date

_____ _____/_____/_____
Signature of Parent/Guardian (minors age 0-17) Date

Attention Staff: This form may only be completed when there is a need to request medical records/films and must be completed in full for each entity you are releasing records from or sending records to.

Under HIPAA, this form is not necessary in order to share or obtain medical information for treatment or payment purposed of the current medical illness.