Authorization For Release Of Medical Record Information

Patient Name: _____ **Date Of Birth:**_____

Address: _____

City: _____ **State:** _____ **Zip:**_____

Phone: _____ **Alt. Phone:**_____

ATTENTION: There may be a charge for medical records

I AUTHORIZE THE FOLLOWING FACILITY TO DISCLOSE MEDICAL INFORMATION:

Person/Organization Name_____

Address _____ Phone #:_____

City_____ State _____ Zip _____ Fax #: _____

Reason for Disclosure:

- ☐ Personal Use
- ☐ Disability Determination
- ☐ Employment
- ☐ Legal Purposes
- ☐ Referral
- ☐ School
- ☐ Billing or Claims
- ☐ Other _____

Dates and Types of Information:

Requesting dates: _____

- ☐ Progress Notes
- ☐ Medication List
- ☐ Lab Results
- ☐ Other: _____

THIS INFORMATION CAN BE USED AND DISCLOSED BY:

Person/Organization Name _____

Address _____ Phone #:_____

City_____ State _____ Zip _____ Fax #: _____

Email _____

Right to Revoke: I understand I may revoke authorization at any time by giving written notice stating intent to revoke authorization to a person or organization. I understand that revocation will not apply to the information piorly released. I understand that the revocation will not apply to my insurance company as law gives insurer the right to contest claims under my policy.

Effective Time Period: This authorization will remain valid for 1 year unless permission is withdrawn, or specifically stated (optional): Month _____ Day _____ Year _____.

Signature Authorization: I understand that authorizing the disclosure of this health informationis voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CRF 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above statements and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

❌_____ _____

Signature of Patient/Guardian/Authorized Representative **Date**

_____ _____

Printed name of authorized representative **Relationship/Capacity to Patient**

_____

Address and Telephone number of authorized representative