

Authorization for Medical Records to be Released

*Please Print

Physician or facility to provide records: _____

Address: _____ Phone: _____

_____ Fax: _____

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

_____ Social Security #: _____

Person to receive records: _____

Address: _____ Phone: _____

_____ Fax: _____

I authorize the health care provider to release information specified below to the organization, agency, or individual named on request. I specifically give permission to release the information regarding the following conditions:

- _____ Substance / Drug Abuse if any
- _____ AIDS / HIV if any
- _____ Psychological or Psychiatric if any

Information to be disclosed:

Initials

1. *Only records generated by this facility
(not including records received from other sources).*
2. *All medical records at their facility.*
3. *Only certain portion of records (please specify below)*

I understand in signing this release I give the permission to release my confidential information to the name above.

Signature: _____ Date: _____

- *To further help us in storing your records, please check the appropriate box.*
 - Please purge my records, as I am transferring care.*
 - Please keep my records current, as I am still a patient in your care.*

Updated 7/2008