PATIENT / CLIENT AUTHORIZATION FOR RELEASE OF INFORMATION

Patient / Client Name: _____

Last   *First*   *MI*   *Maiden or Other Name*

Date of Birth: ____ - ____ - _____   SSN: _____ - _____ - _____   Medical Record #: _____

Address: _____ City: _____ State: _____   Zip: _____

Day Phone: _____   Evening Phone: _____

I hereby authorize _____ to release information from my medical record as indicated below to:

Print Name of Provider

Address: _____ City: _____ State: _____   Zip: _____

Day Phone: _____   Fax: _____

INFORMATION TO BE RELEASED:

DATES

☐ History & physical exam   _____   I specifically authorize the release of information relating to:

☐ Progress notes   _____   ☐ Substance abuse (including alcohol/drug abuse)

☐ Lab reports   _____   ☐ Mental health (including psychotherapy notes)

☐ X-ray reports   _____   ☐ HIV related information (AIDS related testing)

☐ Other:

_____   _____   X_____

_____   _____   SIGNATURE OF PATIENT OR LEGAL GUARDIAN   DATE

PURPOSE OF DISCLOSURE

☐ Legal   ☐ Workers Compensation   ☐ Changing Physicians   ☐ School

☐ Insurance   ☐ Consultation/2nd Opinion   ☐ Continuing Care

☐ Other (please specify): _____

1. I understand that this authorization will expire on _____ (date).
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
4. I understand that if I am being presented to release this information by _____ (provider) for the purpose of:
_____

a. By authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign this form.
b. I understand I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I sign it.
c. I have been informed that _____ (provider) ☐ will ☐ will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
5. I understand that in compliance with _____ (state whose laws govern the provider) statute, I will pay a fee of $_____.
There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment.

_____   _____   OR _____   _____
Signature of Patient   Date   Parent/Legal Guardian/Authorized Person   Date

_____   _____   _____
Records Received By   Date   Relationship to Patient

FOR OFFICE USE ONLY

DATE REQUEST FILLED: _____   REQUEST FILLED BY: _____

IDENTIFICATION PRESENTED: _____   FEE COLLECTED: $_____

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