MR# _____

Authorization for Disclosure of Protected Health Information

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____ Telephone: _____

PLEASE SEND MEDICAL RECORDS TO:

Recipient Name: _____

Recipient Address: _____

Recipient City: _____ State: _____ Zip: _____

Recipient Phone Number: _____ Recipient Fax Number: _____

Recipient Email Address: _____

FROM CLINIC/HOSPITAL:

Clinic/Hospital Name: _____

Clinic/Hospital Phone Number: _____ Clinic/Hospital Fax Number: _____

PURPOSE FOR DISCLOSURE

- ☐ Disability
- ☐ Insurance
- ☐ Attorney
- ☐ Referring Physician
- ☐ Patient Request
- ☐ Other: _____

RECORDS TO BE RELEASED

- ☐ All Medical Records
- ☐ History & Physical
- ☐ Consultation Reports
- ☐ Emergency Room Record
- ☐ Operative Report
- ☐ Discharge Summary
- ☐ Lab/Pathology Reports
- ☐ Radiology Reports
- ☐ Images (check for CD of films)
- ☐ Itemized Billing
- ☐ Other: _____

DATES OF SERVICE

- ☐ Please provide a complete copy of my file for all dates of service
- ☐ Please provide a complete copy of my file for service from _____ through _____.

Please indicate your acceptance by checking the following boxes:

☐ I understand that my records are confidential and cannot be disclosed without my written authorization except when overwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected.

☐ I understand that the specified information could include information about AIDS, HIV, behavior or psychiatric care, alcohol or drug abuse.

☐ I understand that treatment or payment cannot be conditions on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes.

Please allow several days for processing.

EXPIRATION: This Authorization will expire on _____ .

DATE: _____ SIGNATURE: _____

Patient or Legally Authorized Representative

PRINTED NAME: _____

Printed Name of Patient or Legally Authorized Representative