AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name _____ Date of Birth _____
Address _____
Primary Phone _____ Alternate phone _____

✓ **Check the appropriate box and give complete name and address information. THIS SECTION MUST BE COMPLETED**

☐ To GIVE records to: Name: _____
Address: _____
City: _____

☐ To RECEIVE records from: Phone: _____ Fax:_____

I specifically authorize the release of the following information:

___ Office Notes ___ Hospital records ___ Immunizations
___ Diagnostics ___ Laboratory reports ___ Other

I understand if the records contain any of the following information you will need to sign below for it to be released along with any other medical records, otherwise this information will be withheld.

Mental health, ADD/ADHD, Drugs or Alcohol and genetic testing.
If you would like to release any of the above conditions, please sign and date below. **(NOTE: Patient signature is required if they are 13 or older.)**

Signature Date

Signature of patient if 13 or older Date

Purpose of release: ___ Changing provider ___ Consultation ___ Legal
___ Self (Note: a fee will be charged for records requested for personal use)
___ Other: _____

Records release expires: ☐ _____ **or** ☐ **1 year from signed date**

MY SIGNATURE INDICATED THAT I UNDERSTAND AND AGREE TO THE FOLLOWING:

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS test or result information, mental health, drug or alcohol treatment or referral information.
I understand that the person or entity I am authorizing to use and/or disclose the information may receive compensation for doing so.
I understand this is not a blanket authorization for release of information. It is intended for a one-time use only.
I understand that this authorization may be revoked at any time unless prior action has been taken as a result of this form. Revoking of this release will require a separate signature. Please notify the office.

Signature of Patient/Parent/Legal Guardian Relationship to patient Date

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