

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name _____
Social Security # _____ Birth Date: _____
Other Name(s) if applicable _____

This will authorize _____ to release and/or exchange medical
Name & Address
information on the above listed patient to:

Name/Organization
Street
City State Zip

The following information is to be released (check appropriate boxes):

- Discharge Summary
Counselor's Discharge Summary
History and Physical
Operative Report
Pathology Report
Psychological Testing
X-ray Reports
Lab Reports
EKG/EEG reports
Outpatient / ER report
Consultation report
Other (specify)

The following time period or condition: _____

I am requesting this information for use by:

- Medical Personnel/ Health Care Facility
Insurance Company
Attorney
Personal
Other (Specify)

- All records pertaining to psychiatric/mental health, chemical dependency and/or AIDS/HIV related illness/testing will be released unless otherwise indicated by a check mark here:
I understand that there may be a retrieval and copy charge associated with the release.
I do not authorize further release by the receiving requestor to any third party. I understand that once information is released pursuant to this authorization the facility or physician named above cannot prevent the re-disclosure of that information.
I understand that I may revoke this consent at any time, and that the consent will automatically expire one year from the date of my signature.

Signature of Patient _____ Date _____

Signature of Authorized Person _____ Date _____ Relationship to Patient _____

Reason Patient is unable to sign: Minor Deceased Other _____