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## AUTHORIZATION TO RELEASE MEDICAL RECORDS

I authorize the use and/or disclosure of my protected health information (medical records) described below:

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

I authorize the following to RELEASE my protected health information (Please include name of facility/provider, address, phone/fax number):

\_\_\_\_\_

I authorize the following to RECEIVE my protected health information (Please include name of facility/provider, address, phone/fax number):

\_\_\_\_\_

The purpose of the release is:

\_\_\_ At the request of individual \_\_\_ Diagnostic Evaluation \_\_\_ Coordination of Care \_\_\_ Change of Physician

\_\_\_ Other: \_\_\_\_\_

The following information may be released:

All medical records \_\_\_ Labs \_\_\_ Problem list \_\_\_ Imaging \_\_\_ Medical Summary

\_\_\_ Progress Notes \_\_\_ Medication Records \_\_\_ Operative reports \_\_\_ Pathology

\_\_\_ Other \_\_\_\_\_

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

HIV/AIDS information  Genetic testing information  Mental Health information

Drugs/alcohol diagnosis, treatment, or referral information

Please send my records for the following Dates of service: From: \_\_\_\_\_ through \_\_\_\_\_.

- ✓ This authorization will expire 180 days from the date signed.
- ✓ You have the right to revoke this Authorization at any time, provided you do so in writing. If you revoke your Authorization we will no longer use or disclose information about you for the reasons covered by your written authorization, but we cannot take back any disclosures already made with your permission. To revoke your records release with this authorization, please send a written statement to our clinic at 2250 NW Flanders St., Ste. 205, that identifies the date you signed the authorization, the recipient of the information in the authorization and state you are revoking this authorization.

I have reviewed and I understand this authorization. I also, understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

\_\_\_\_\_  
(Signature of patient or representative)

\_\_\_\_\_  
Relationship (if signed by representative)

\_\_\_\_\_  
(Date)

Updated 09/16