Authorization for Release of Medical Information

I authorize _____

(Name of Hospital, Physician Office, Physician, or other)

_____

(Address)

_____

(City, State, Zip code)

to release my confidential medical records concerning treatment to:

_____

_____

_____

(The medical records checked below have been authorized to be released)

I consent to the release of the following information: (please check appropriate boxes)

☐ I do

☐ I do not give special permission to release any information regarding:
Psychological/Psychiatric/Mental Health, HIV Information, and/or Substance Abuse

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☐ Hospital Records	☐ Operative Reports	☐ Progress Notes
☐ Physician Office Reports/Notes	☐ X-Ray Reports	☐ EKG/Stress test/Catheterization Reports
☐ Discharge Summary	☐ Consultations	☐ Other: _____
☐ History & Physical	☐ Laboratory Reports	_____

I may revoke this authorization at any time in the form of written notice from me, except for purposes of providing information to insurance companies to ensure payment for the treatment or for research purposes. This consent will automatically expire from the date below.

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I HAVE READ, UNDERSTAND, AND AGREE TO THE CONTENTS OF THIS CONSENT.
The above named facility/person is released from any liability that might arise from this action. I understand in some instances I will be charged for the copying of the records.

_____ _____
Patient Printed Name Date of Birth Contact Phone Number

_____ _____
Address, City, State, Zip Code Social Security Number

_____ _____
City, State, Zip Code Relationship to Patient

_____ _____
Patient/Legal Responsible Persons Signature Date **Witness/Witnesses**

The patient is unable to consent because: _____

ANY RE-DISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENT(S) IS PROHIBITED WITHOUT THE CONSENT OF THE PATIENT OR OTHER LEGALLY AUTHORIZED PERSON(S)