Medical Records Release Form

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF COMMUNICABLE OR VENERAL DISEASE, WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, HERPES, SYPHILIS, GONORRHEA, AND HUMAN IMMUNE DEFICIENTY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).

SECTION I.
INFORMATION PERTAINING TO

PATIENT'S NAME	BIRTHDATE		SOCIAL SECURITY NUMBER

I AUTHORIZE AND REQUEST_____
(Name of Person or Agency Releasing Information)

RELEASE COPIES OF MEDICAL RECORDS TO:	OBTAIN COPIES OF MEDICAL RECORDS FROM:

PURPOSE OF THIS RELEASE: □CONTINUITY OF CARE □MEDICAL PAROLE □OTHER _____
□SOCIAL SECURITY/DISABILITY □PERSONAL USE □LEGAL PURPOSES

THE EXTENT OR NATURE OF INFORMATION TO BE RELEASED: TIME PERIOD FROM_____TO_____

□PROGRESS NOTE □RADIOLOGY □MENTAL HEALTH □PHYSICIAN'S ORDERS
□LAB WORK □OPTHALMOLOGY □HISTORY AND PHYSICAL □DENTAL
□ENTIRE MEDICAL RECORD □OTHER_____

DATE UPON WHICH AUTHORIZATION EXPIRES: _____(If left blank will expire in 1 year)

I UNDERSTAND THIS AUTHORIZATION MAY BE REVOKED IN WRITING AT ANY TIME UNLESS ACTION HAS ALREADY BEEN TAKEN BASED UPON IT, AND THAT IN ANY EVENT THIS AUTHORIZATION EXPIRES IN ONE YEAR FROM THE DATE OF SIGNING OR UPON THE CONDITIONS(S) DESCRIBED ABOVE.

_____

Patient Date

_____

Legal Representative/Guardian Describe authority to act on behalf of the individual Date

CERTAIN STATUTES, STATE AND FEDERAL, MAY PROHIBIT FURTHER DISCLOSURES OR RELEASE OF THE ABOVE INFORMATION WITHOUT SPECIFIC WRITTEN AUTHORIZATION FOR RELEASE OF THE PERSON(S) ABOUT WHOM IT PERTAINS. THIS AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION IS NOT INTENDED TO AUTHORIZE FURTHER RELEASE OR DISCLOSURE. REDISCLOSURE OF MY MEDICAL RECORD BY THOSE RECEIVING THE ABOVE INFORMATION MAY BE ACCOMPLISHED WITHOUT MY FURTHER WRITTEN AUTHORIZATION AND MAY NO LONGER BE PROTECTED.

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