



Authorization for Release of Patient Information

Patient Name: _____

Date of Birth: _____

Phone Number: _____

Social Security #: _____

Source of Information: _____

Address: _____ City, State, Zip _____

Destination of Information: _____

Address: _____ City, State, Zip _____

Specific information to be disclosed: Entire record or specify: _____

Specific information not to be disclosed: _____

Purpose of information disclosure: _____

Expiration of release: _____ (Will expire in one year if left blank)

The above named patient authorizes the above named source or health care provider to disclose all records in their possession relating to the patient's physical and mental health, evaluation and treatment. This includes all records and information regarding the patient's physical and mental health or injuries, including labs, diagnostic imaging studies, hospital records, consultation reports, any records from other sources, facilities or providers that are part of the patients medical record, correspondence, treatment or evaluation made or provided by any physician, physiatrist, psychiatrist, psychologist, nurse, chiropractor, osteopath, physical or occupational therapist, or any other health care provider. This may include information regarding mental health, drug and alcohol abuse, STD, HIV, AIDS, developmental disabilities and genetic testing unless specifically excluded above. This authorization includes records that are created after the date of this authorization until the expiration date.

I understand that I have the right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing. I understand that I have a right to inspect and/or receive a copy of the health information released and I may be charged a fee for any copies of the medical records that I receive. I understand that, if the persons or organizations I authorize to receive and/or use the protected health information described in this form may further disclose the protected health information and it may no longer be protected by federal health Law. I understand that I may refuse to sign this authorization, and that refusal will not affect my ability to obtain treatment. A photocopy of this document shall be considered as valid as the original.

This authorize includes medical records for treatment rendered after the date of this authorization and release of copies of any medical information or treatment records accumulated after my signature through the expiration date of this authorization. A photocopy, facsimile, or electronic image of this authorization shall be as valid as the original.

Signature of Patient or legally authorized representative: _____

Name of legally authorized Representative: _____

Date: _____