



# MEDICAL RECORDS RELEASE AUTHORIZATION

Upon presentation of this authorization, you are requested to provide the records outlined below.

**Patient Info:** \_\_\_\_\_

Patient Name			Phone/Email			DOB								
<b>To:</b> _____						<b>From:</b> _____								
Where to send medical records						Location the medical records are being sent from								
Address			Suite/Bldg/Number			Address			Suite/Bldg/Number					
City			State			City			State			Zip Code		
Phone			Fax			Phone			Fax					

**Dates of Service (Check one and complete dates of service if required):**

- ☐ Please provide a complete copy of my file
- ☐ Please provide a complete copy of my file for dates of service from \_\_\_\_\_ through \_\_\_\_\_

**Method of Delivery:** ☐ Mail a Paper/Hard Copy ☐ Email Digital Copy / Link to Digital Copy ☐ Fax (see above)

**Records to be Released:**

- ☐ History & Physical ☐ Consultation Report(s) ☐ ER Record(s) ☐ Operative Report(s) ☐ Lab/Pathology Report
- ☐ Discharge Summary ☐ Radiology Report(s) ☐ Radiology Image(s) (CD) ☐ Itemized Billing
- ☐ Other: \_\_\_\_\_

**Purpose for Disclosure:**

- ☐ Disability ☐ Insurance ☐ Attorney ☐ Referring Physician ☐ Patient Request ☐ Other: \_\_\_\_\_

**Please indicate your acceptance by checking the following boxes:**

- ☐ I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization (45 CFR § 164.508(c)(2)(i)).
- ☐ I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes (45 CFR § 164.508(c)(2)(ii)).
- ☐ I understand that my records are confidential and cannot be disclosed without my written authorization except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I Understand that the specified information to be released may include, but is not limited to: history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) (45 CFR § 164.508(c)(2)(iii)).

This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time.

Date	Printed Name of Patient or Authorized Representative	Signature of Patient or Legally Authorized Representative
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