

Name: \_\_\_\_\_  
DOB: \_\_\_\_\_  
Chart: \_\_\_\_\_  
Age: \_\_\_\_\_  
Date: \_\_\_\_\_



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## Medical Records Release Authorization

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

### To Recipient:

Person/Company

Address

City

State

Zip

Phone Fax

### From Clinic/Hospital:

Clinic or Hospital

### Patient:

Patient Name

Phone

Date of Birth

Email address

### Dates of Service (Check One and Complete Dates of Service if Required)

Please provide a complete copy of my file for all dates of service

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

### Records to be Released (45 CFR § 164.508(c)(1)(i)).

All Medical Records (no films)

Emergency Room Record

History & Physical

Operative Report

Consultation Reports

Discharge Summary

Lab/Pathology Reports

Radiology Reports

Images (check for CD of films)

Itemized Billing

Other \_\_\_\_\_

### Purpose for Disclosure

Disability

Insurance

Attorney

Referring Physician

Patient Request

Other (please state reason)

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 re-disclosure 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: \_\_\_\_\_ Signature: \_\_\_\_\_

Patient or Legally Authorized Representative

Printed Name of Patient or Legally Authorized Representative