AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient name (print) ____**DOB:**_________________________

Information to be **Obtained** from:

Name of facility or provider: ____
Address: ____

Information to be **Sent** to:

Name of designated recipient: ____
Address: ____

Information to be released (check one):

☐The most recent 2 years of pertinent information (chart notes, labs, x-rays, and special tests)

☐All medical records

☐Specific information (please specify) ____
EMAIL (**if screening photo is being requested):** ____

Purpose for which the disclosure is being made (please check one):

☐ **Doctor** ☐ **Insurance** ☐ **Personal** ☐ **Attorney**

PATIENT AUTHORIZATION: I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted infections, drug and alcohol abuse, mental illness, or psychiatric treatment. I give my explicit authorization for these records to be released.

***Exclude the following information from my records (please check all that apply)**

☐Drug/Alcohol abuse/treatment & diagnosis ☐ Sexually transmitted infections

☐HIV/AIDS diagnosis/treatment/testing ☐Mental illness or psychiatric diagnosis/treatment

MY RIGHTS: I understand I do not have to sign this authorization in order to obtain health care benefit (treatment, payment, or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person may re-disclose it, at which time it may no longer be protected under privacy laws.

Signature: ____ **Date:** ___________________________
(Patient, guardian, or authorized representative)

This authorization will expire 90 days from the date signed. Possible copying fee required.