



**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

\_\_\_\_\_  
Print Patient full name  
\_\_\_\_\_  
Street address  
\_\_\_\_\_  
City/State/Zip

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Birth date  
\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
Social Security Number  
(\_\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_  
Home phone number

At the request of the individual, I \_\_\_\_\_, do hereby authorize

\_\_\_\_\_ to release:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Discharge Summary  | <input type="checkbox"/> Pathology Reports    | <input type="checkbox"/> Emergency Reports |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Laboratory Reports   | <input type="checkbox"/> Other _____       |
| <input type="checkbox"/> Progress Notes     | <input type="checkbox"/> Radiology Reports    | _____                                      |
| <input type="checkbox"/> Operative Notes    | <input type="checkbox"/> ECG/EEG/Cardiac Cath | _____                                      |

I do  I do NOT authorize release of information related to AIDS(Acquired Immunodeficiency syndrome) or HIV(Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

**PLEASE RELEASE INFORMATION TO:**

\_\_\_\_\_  
Name of Company/Agency/facility/Person  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City/State/Zip

**PURPOSE OF DISCLOSURE:**

- |   |   |                                       |  |
|---|---|---------------------------------------|--|
| <input type="checkbox"/> Referral to specialist | <input type="checkbox"/> Insurance                | <input type="checkbox"/> Workers Comp | <input type="checkbox"/> Change of Doctor/Provider |
| <input type="checkbox"/> Legal Investigation    | <input type="checkbox"/> Disability determination | <input type="checkbox"/> Personal     | <input type="checkbox"/> Continuing care           |
- Other(please specify)\_\_\_\_\_

**Please provide the best telephone number in the event we need to contact you (home or work or cell) (\_\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_**

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished many not condition its treatment of me on whether or not I sign the authorization.

\_\_\_\_\_  
**Signature of individual or guardian or  
Personal Representative of patient's estate**

\_\_\_\_\_  
**Date**

**NOTE:** There may be a charge for a personal copy or the permanent transfer of your records as follows: a \$10 base fee, \$.50 per page for pages 1-50, then \$.25 for any pages over 50.