

Patient: Name _____ Date of Birth _____

Address: _____ Social Security #: _____

City _____ State _____ Zip _____ Day Phone #: _____

Information released from:

Physician/Clinic name: _____ Phone _____

Address: _____

City: _____ State _____ Zip _____

Recipient: Information released to:

Name: _____ Phone _____

Address: _____

City: _____ State _____ Zip _____

Medical record information to be released: start date _____ end date _____

- | | |
|---|---|
| <input type="checkbox"/> Office visit/telephone notes | <input type="checkbox"/> Abstract/pertinent information |
| <input type="checkbox"/> Mammogram Results | <input type="checkbox"/> Prenatal Records |
| <input type="checkbox"/> Pap Results | <input type="checkbox"/> Ultrasound |
| <input type="checkbox"/> Lab/test results | <input type="checkbox"/> DEXA(Bone Density) |
| <input type="checkbox"/> Hospital reports | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Operative Procedure Reports | |

The following information will be released when included in the above information unless you indicate otherwise.

- Treatment for Alcohol and/ or Drug Abuse (Substance abuse)
- Psychiatric or mental care/treatment
- HIV related information (AIDS related testing)
- Sexually Transmitted Disease related- information and testing
- Genetic testing

Reason for release:

- | | |
|---|---|
| <input type="checkbox"/> Consult/second opinion, personal | <input type="checkbox"/> Selected new physician |
| <input type="checkbox"/> Legal | <input type="checkbox"/> Referred by Dr/continuing care |
| <input type="checkbox"/> Insurance underwriting | <input type="checkbox"/> School |
| <input type="checkbox"/> Out of town move | <input type="checkbox"/> Other _____ |

- > I understand I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.
- > I understand when my information is used or disclosed pursuant to this authorization it may be subject to redisclosure by the recipient and may no longer be protected by Federal HIPAA privacy rule.
- > I understand that I may revoke this authorization at any time (provided such revocation is in writing to the providing organization's privacy official) except to the extent that the practice has acted in reliance upon this authorization.
- > The consent will automatically expire on the following date, event _____ or if not indicated in one year.
- > I have a right to receive a copy of this form after I sign it.

I authorize the above provider to release the information marked above to the recipient.

Signed by:

Signature of patient

Date

Patient's Name(print)

Signature of legal guardian

Date

Legal Guardian Name(print)