

## Authorization to Release Medical Information

1. I, \_\_\_\_\_, hereby authorize \_\_\_\_\_ (Physician or Group Practice) to disclose the following specific medical information by mail or fax to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

2. I specifically authorize the release of the following specific information:

\_\_\_\_\_ Records of clinic visits

\_\_\_\_\_ X-rays

\_\_\_\_\_ Statement of charges and payments

\_\_\_\_\_ Copies of outside medical reports contained in my medical record

\_\_\_\_\_ All of the above

Include

Do not include

\_\_\_\_\_      \_\_\_\_\_      HIV information

\_\_\_\_\_      \_\_\_\_\_      Alcohol and drug information

\_\_\_\_\_      \_\_\_\_\_      Hepatitis B information

\_\_\_\_\_      \_\_\_\_\_      Mental health information

3. Records requested pertain specifically to my medical condition beginning on \_\_\_\_\_, 20\_\_.

4. This information may be used for the specific purposes designated below:

\_\_\_\_\_      Second opinion by another physician, Dr. \_\_\_\_\_

\_\_\_\_\_      Insurance company

\_\_\_\_\_      Disability determination

\_\_\_\_\_      Attorney, \_\_\_\_\_

\_\_\_\_\_      Other (Specify) \_\_\_\_\_

5. I understand that my records are confidential and cannot be disclosed without my written authorization, except as otherwise provided by law.
6. I understand that a photocopy of this authorization is valid as the original.
7. I understand that I may revoke this authorization at any time. In the absence of my prior revocation, this authorization will automatically expire in one year.

Signature of Patient/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

Social Security # or Drivers' License # (for identification): \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_