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Authorization to Disclose Medical Records

This authorization must be written, dated and signed by the patient or by a person authorized by law to give this authorization.

I authorize ________________________________ to release a copy of the medical information
(name of hospital/health care provider)

for ________________________________ to ________________________________ .
(name of patient) (name of and address of recipient)

This information will be used on my behalf for the following purpose(s): ________________________________

____

By initialing the spaces below, I specifically authorize the release of the following medical records, if such records exist:

______ All hospital records (including nursing records and progress notes)
______ Transcribed hospital records
______ Medical records needed for continuity of care
______ Laboratory reports
______ Pathology reports
______ Diagnostic imaging reports
______ Most recent five-year history
______ Clinician office chart notes
______ Dental records
______ Physical therapy records
______ Billing statements
______ Other: ____________________

______ Please send the entire medical record (all information) to the above named recipient. The recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record.
______ HIV/AIDS related records (Must be initialed to be included in other documents)
______ Mental health information (Must be initialed to be included in other documents)
______ Genetic testing information (Must be initialed to be included in other documents)
______ Drug/Alcohol diagnosis, treatment or referral information as listed on back (Federal Regulation 42CFR Part 2 requires a description of how much and what kind of info is to be disclosed. Provide a specific description of information on reverse of this form).
______ This authorization is limited to the following treatment:

____

This authorization is limited to the following time period:

____

This authorization is limited to workers' compensation claim for injuries of

____ Date __________

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

______________ ________________________________
Date Signature of patient or person authorized by law