Authorization to Release Medical Records/Information

Patient Name_____Social Security Number_____

DOB_____

Requests Medical Records from:

Facility Name_____

Address_____

Phone#_____Fax#_____

Authorizes medical records to be sent to:

Facility Name_____

Address_____

Phone#_____Fax#_____

I authorize the health care provider to release the information specified below to_____. Release information generated by this facility. I specifically authorize the release of information regarding the following conditions: check any that apply.

____Drug abuse if any ____Substance abuse if any ____Psychological or psychiatric conditions if any

____AIDS/HIV if any ____Other:_____

Expiration or revocation of authorization: I understand that I may revoke this authorization at any time.

Use of copies: A copy of this authorization may be utilized with the same effectiveness as an original.

Patient Name_____

Signature_____

Date_____

Person authorized to sign for patient_____

Signature_____Date_____

Relationship to Patient_____