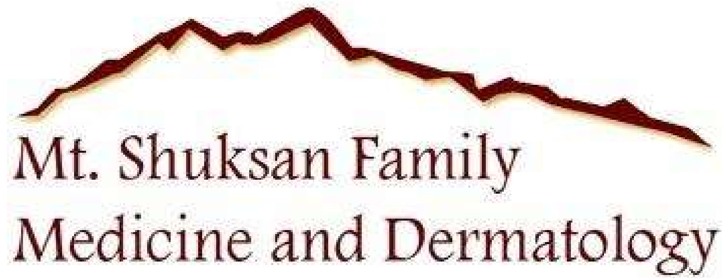

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Name: ____ **DOB:** ________ **SSN:** _________

INFORMATION TO BE RELEASED FROM:

Provider Name/Facility: ____

Address: ____

____

Phone#: ___________________________________ Fax#: ___________________________

INFORMATION TO BE DISCLOSED: (check one)

- ☐ Most Recent (2 years) medical records
- ☐ All Medical Records
- ☐ Specific Information (Please specify): ________________________________

PURPOSE OF DISCLOSURE: (check one)

☐ Transfer of Care ☐ Personal ☐ Insurance ☐ Attorney

PATIENT AUTHORIZATION:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

To **EXCLUDE the following information from the records release **(please initial)**

___Drug/Alcohol Abuse/Treatment ___Sexually Transmitted Diseases ___HIV/AIDS Virus ___Mental Health/Psychiatric Disorders

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may redisclose it, at which time it may no longer be protected under Privacy laws.

Signature: ____ Date: _________________

(Patient, Guardian, or Authorized Representative)