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A Professional Corporation

RELEASE OF MEDICAL RECORDS

Name: ______________________________ **Date of Birth:** ______________

Address: ____

____

____

Social Security #: ______________________ **Phone:** ______________

Requester:
Where do you want your information sent

Name: ______________________________
Address: ______________________________
____

Provider:
Who is releasing your information

Name: ______________________________
Address: ______________________________
____

Information Requested:

- ☐ Complete Record
- ☐ Lab, Data, Date
- ☐ EKG, Date
- ☐ History & Physical
- ☐ Specific Progress Note (please list date needed)______________
- ☐ Other______________(please be specific)
- ☐

Purpose of Release:

- ☐ Transferring Medical Care
- ☐ Insurance Coverage
- ☐ Moving
- ☐ Other

READ CAREFULLY: I understand that my medical records are confidential. I understand that by signing this authorization I am allowing the release of my medical information requested to the agency or person specified above. Drug and alcohol abuse information records are specifically protected by federal regulations and by signing this authorization, I am allowing the release of any drug, alcohol and/or psychiatric information records to the agency or person specified above. I understand that my records may contain information regarding the diagnosis and treatment of HIV (AIDS virus) and other sexually transmitted diseases and by signing this authorization, I am allowing this information to be released to the agency or person specified above. I also understand that I may revoke this authorization at any time by written request from myself or my family except to the extent that action has already been taken in reliance upon it.

This consent shall remain in effect for six (6) months from the date executed unless revoked earlier by me. If revoked earlier, it is understood by all parties that the information release prior to being notified or such revocation was made at my request with my consent.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this consent.

Date:	Signature:
	If signed by personal representative, state relationship/authority to do so
Date:	Signature:

THE FOLLOWING APPLIES ONLY TO DRUG/ALCOHOL ABUSE OR TREATMENT INFO. RECORDS:
Prohibition on disclosure: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulation 42-CFR-2 prohibits you from making further disclosure of it without the specific written consent of the person to who it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.