AUTHORIZATION FORM FOR RELEASE OF MEDICAL INFORMATION

Patient's Full Name ______________________ Birth date (MM/DD/YY) ______________

Street Address ______________________ City, State, Zip Code ______________

Phone # ______________________ Social Security # ______________

At the request of the individual, I ______________________, do hereby authorize the release of records of:

______ Discharge Summary
______ Pathology Reports
______ ER Reports
______ Physical & History
______ Lab Reports
______ Other
______ Progress Notes
______ Radiology Reports
______ Operative Reports
______ ECG /EEG/ Cardic Cath

_____I do _____I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/ or psychological assessment, and treatment for alcohol and/or drug abuse.

Information to be released covers the time from ___________ to _____________

INFORMATION RELEASE TO:

____

____

INFORMATION RELEASE FROM:

____
Name of the Company/Facility /Person

____
Street Address

____
City, State, Zip

____
Phone #

____
Fax #

PURPOSE:

___ Change physician ___ Insurance ___ Referral to Specialist ___ Legal Investigation
___ Disability Determination ___ Personal ___ other

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of the signature. I understand that I may cancel this request with written notification but that it will not effect any other information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

______________________ ______________
Signature of individual or guardian or personal Representative of patient's estate
Date