## 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