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MEDICAL RECORD RELEASE OF INFORMATION

Patient Name: _____ **Date of Birth** _____

The undersigned individual or organization is authorized to make the disclosure: **(REQUESTING FROM)**

Physician/Clinic/Hospital _____

Address _____

City/St/ZIP _____

The type and amount of information to be disclosed is as follows:

- All Records
- 2 years back with most recent test results
- 5 years back with most recent test results
- Specific Information: _____

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed to and used by the following individual or organization:

TO RELEASE TO: (TO BE SENT TO)

Physician/Clinic/Hospital _____

Address _____

City/St/ZIP _____

For the purpose of _____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that this revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will not expire. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR.163.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosures.

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 authorization.

X _____
Signature of Patient/Guardian

Date