AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Complete Lines 1-8. (Numbers 9-11 are optional)

1. Patient's Name _____
(First) (Middle) (Last)

2. Date of Birth _____ Patient Phone _____

Permission is hereby granted for release of information

3. ***FROM:*** Name: _____
Address: _____
_____

4. ***TO:*** Name: _____
Address: _____
_____
Phone: _____ Fax: _____

Authorization for release
OFFICE USE ONLY
_____
Dr.'s initials

5. The purpose of the release is ☐ Diagnostic Evaluation ☐ Follow-up Care Legal ☐
☐ Reimbursement ☐ Other _____

6. The following information may be released:
☐ Clinic Notes (RE:_____) ☐ Laboratory Reports ☐ X-ray Films ☐ All Records
☐ Immunization Records ☐ Medication Records ☐ X-ray Reports
☐ Other _____
_____

7. _____ _____ _____
(Signature of Patient or Representative) Relationship (if signed by representative) Date Signed

8. I do ☐ / do not ☐ specifically consent to transmission of my medical records via a facsimile (fax) machine.

_____ _____
(Signature) (Date)

9. I recognize that the information disclosed may contain ***drug/alcohol*** information that is protected by federal and state law. I specifically consent to disclosure of such information.

_____ _____
(Signature) (Date)

10. I recognize that the information disclosed may contain ***mental health*** information that is protected by federal and state law. I specifically consent to disclosure of such information.

_____ _____
(Signature) (Date)

11. I recognize that the information disclosed may contain information regarding ***sexually transmitted diseases or HIV/AIDS*** testing information. I specifically consent to disclosure of such information.

_____ _____
(Signature) (Date)

This consent will expire on _____ (maximum 3 years)
This consent is subject to revocation at any time except to the extent that action has been taken in reliance upon this consent before notice of revocation was received. (Back records for a maximum of two years only).

Medical Records Coordinator
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Fax: 503.224.0722
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