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Authorization to Release Medical Records/Information

Physician to provide records: _____
Physician's Phone Number: _____
Patient's Name: _____ Date of Birth: _____
Social Security Number: _____

Person/Facility to receive records: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____

1. Release all health care information: _____
2. Health care information relating to the following treatment, condition, or dates: _____
3. Other: _____

If you do not want certain portions of your medical records released, please read this section carefully and initial spaces for information you do not want released. Otherwise, your records will be released as specified as above.

I authorize the health care provider to release the information specified to the organization, agency, or individual named on this request, with the Exception of:

Substance abuse, if any: _____ AIDS/HIV, if any: _____
Psychological or psychiatric conditions, if any: _____
Other (please specify): _____

Expiration or revocation of authorization—I understand that I may revoke this authorization at any time and unless an earlier date is specified, it will automatically expire 12 months after the date affixed below. Use of copies—A copy of this authorization may be utilized with the same effectiveness as an original.

Patient Signature: _____ Date: _____
Person authorized to sign for patient: _____
Relationship to patient: _____ Date: _____