



**AUTHORIZATION FOR RELEASE OF INFORMATION**

**PATIENT INFORMATION:**

\_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SS#: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

*(PRINT NAME OF PATIENT)*

**FORMER PHYSICIAN'S INFO:** NAME: \_\_\_\_\_

ADDRESSES: \_\_\_\_\_

CITY / STATE / ZIP: \_\_\_\_\_

**INFORMATION TO BE SENT TO:** NAME: \_\_\_\_\_

ADDRESSES: \_\_\_\_\_

CITY / STATE / ZIP: \_\_\_\_\_

**INFORMATION TO BE RELEASED:**

- The most recent 2 years of pertinent information (chart notes, labs, x-rays, and special tests)
- All medical records
- Other (Please Specify) \_\_\_\_\_

**\*EXCLUDE THE FOLLOWING INFORMATION FROM THE RECORDS RELEASED (PLEASE INITIAL):**

\_\_\_\_\_ Drug/Alcohol abuse/treatment & diagnosis      \_\_\_\_\_ Sexually Transmitted Disease  
 \_\_\_\_\_ HIV/AIDS diagnosis/treatment/testing      \_\_\_\_\_ Mental Illness or Psychiatric diagnosis/treatment

**PATIENT AUTHORIZATION:**

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

**MY RIGHTS:**

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

*(Patient, Guardian\*, or Authorized Representative\*).*

[\*Please provide documents to prove authority to sign on behalf of the patient.]

**THIS AUTHORIZATION WILL EXPIRE 90 DAYS FROM THE DATE SIGNED.**

**POSSIBLE COPYING FEE REQUIRED**

*If you desire a copy of this authorization, please notify the Clinic Receptionist upon completion of this form.*