AUTHORIZATION TO RELEASE PATIENT MEDICAL INFORMATION

PATIENT INFORMATION

Patient Name _____ Medical Record # _____

Former Name (if any) _____ Social Security # _____

Daytime Telephone _____ Birthday _____

I HEREBY AUTHORIZE _____
Name of Organization

_____
Street Address City, State Zip Code

to release the following medical information contained in the patient's medical record.

RELEASE INFORMATION TO:

_____
Name of Organization

_____
Street Address City, State Zip Code

Purpose or need for this information is: _____

TYPE OF INFORMATION TO BE RELEASED *DATES OF TREATMENT*

☐ **Medical Records/Excluding Protected Records** From_____ To _____
(this will be limited to 2 years of information including Lab, x-ray reports unless otherwise stated)

☐ **Medical Records - Complete Records -** From_____ To _____
Excluding Protected Records

☐ **Other Records** (specify) _____ From_____ To _____

- **INFORMATION PROTECTED BY STATE/FEDERAL LAW:**

☐ **Drug Abuse Diagnosis/Treatment*** From_____ To _____

☐ **Alcoholism Diagnosis/Treatment*** From_____ To _____

☐ **Mental Health Diagnosis/Treatment**** From_____ To _____
(may include treatment in Pain Management and Center for Women's Health or Psychiatry)

☐ **Sexually Transmitted Disease Diagnosis/Treatment or Counseling***** From_____ To _____
(Includes AIDS/HIV)

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

_____
Date Signature of Patient/Legally Responsible Party (Relationship to Patient if not Patient)

AUTHORIZATION VALID FOR 90 DAYS ONLY AND MAY BE REVOKED IN WRITING AT ANY TIME PRIOR TO 90 DAY BY NOTIFYING THE MEDICAL RECORD DEPARTMENT. TO BE VALID AUTHORIZATION MUST BE SIGNED AND DATED. SEE BACK OF FORM FOR FURTHER INFORMATION