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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(Important: ALL sections MUST be complete.)

Patient Name: _____ Birth Date: _____

Address: _____ Phone: (____) _____

_____ SS#: _____

Release From: _____ Release To: _____

_____ _____

By placing a check mark in the space below, I permit the release of the following records from _____ to _____ : (If no time period is specified, record from previous 5 years only will be released.)

___ Complete medical records
___ Lab reports
___ Pathology reports
___ Imaging reports
___ EKG/cardiac reports
___ Physical/occupational therapy reports
___ Bills
___ Physician/clinical records
___ Implant details (including operative report)
___ Photos

___ All hospital/institution records (nursing records/progress notes)
___ Hospital/institution records (surgical, history/physical exam reports, consultation reports, discharge summary)

Purpose of disclosure:

[ ] Disability [ ] Social Security [ ] Insurance

[ ] Worker's Comp [ ] Attorney Request

[ ] Other: [ ] Transfer of Care – Reason:

There is a minimum fee of $20.00 for the release of medical records which is the responsibility of the patient to pay prior to receiving the records. For records that exceed twenty (20) pages, there may be an additional charge of $0.20 per page.

I understand that my medical records may contain information **related to communicable diseases and infection information** as defined by statute and **Department of Public Health Rules** (which include venereal disease "VD," tuberculosis "TB," Hepatitis (any form), Human Immunodeficiency Virus "HIV", Acquired Immunodeficiency Syndrome "AIDS" and AIDS Related Complex "ARC;" **alcohol and/or drug abuse treatment information** protected under regulations in 42 Code of Federal Regulations, Part 2; and **mental health treatment records, psychological services** and/or **Social Services** information including communications made to or by a social worker, psychologist or psychiatrist.

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 Privacy Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire after one (1) year.

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 ensure treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. 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. I understand that I may request a copy of this authorization. If I have questions about disclosure of my health information, I may contact the Privacy

Office at the disclosure location.

Signature of Patient or Patient Representative	Date/Time
Printed Name of Patient or Patient Representative	Relationship to Patient (If Patient Representative)