AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____
Patient Name (Please Print)

Address: _____
(Street) (City/State) (ZIP)

Phone: ( ) _____ Date of Birth: _____

Social Security Number: _____

hereby authorize _____ to release copies of my medical records to the following:

REQUESTOR: _____

ADDRESS: _____

_____

Reason for Release:

_____ Change in Insurance _____ Moving

_____ Additional Information from Specialist _____ Changing Doctors

I understand that only the last 3 years of physician notes, x-ray reports, laboratory reports, and diagnostic test results will be released unless otherwise indicated below:

_____

I also understand that these records may contain information pertaining to drug abuse and/or alcoholism, HIV/AIDS or psychiatric/psychological information and that these will be included unless otherwise specified.

ALL PATIENTS 18 OR OLDER MUST SIGN THIS FORM BEFORE RECORDS CAN BE RELEASED

_____ _____
Signature of patient or authorized representative Date

Prohibition or Redisclosure: This information has been given to you from confidential records. You are prohibited from making disclosure of this information except with the specific written consent of the person to who it pertains and the facility for which the information originates.