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**Authorization to Use/Release/Disclose Medical Information**

Patient Name (please print) \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Telephone \_\_\_\_\_ Work Telephone \_\_\_\_\_ Ext. \_\_\_\_\_

**Persons/Organizations Providing the Information:**

**Persons/Organizations Receiving the Information:**

Name \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

Telephone # \_\_\_\_\_

Telephone # \_\_\_\_\_

Fax # \_\_\_\_\_

Fax # \_\_\_\_\_

I, \_\_\_\_\_, I do hereby authorize the following information to be sent to  
Patient Name

the address above: \_\_\_\_ Copies of all Medical Records \_\_\_\_ Progress Notes \_\_\_\_ History & Physical  
\_\_\_\_ Pathology Reports \_\_\_\_ Radiology Reports \_\_\_\_ Laboratory Reports  
\_\_\_\_ Other (please specify) \_\_\_\_\_

From the time period of \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_.

\_\_\_\_ I do \_\_\_\_ I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, Psychological assessment, and treatment for alcohol and/or drug abuse.

Purpose or use of disclosure: \_\_\_\_ Transferring to another physician (please give reason) \_\_\_\_\_  
\_\_\_\_ Patient's Request \_\_\_\_ Moving \_\_\_\_ Insurance \_\_\_\_ Workers Comp  
\_\_\_\_ Legal Investigation \_\_\_\_ Disability \_\_\_\_ Referral to Specialist \_\_\_\_ Personal  
\_\_\_\_ Other (please specify) \_\_\_\_\_

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date

**PLEASE NOTE: THERE WILL BE A CHARGE FOR RECORDS WHEN REQUESTED FOR PERSONAL REASONS OR PERMANENT TRANSFER.**

**OFFICE USE ONLY:**

Patient Chart# \_\_\_\_\_ Date Information Disclosed \_\_\_\_/\_\_\_\_/\_\_\_\_ By \_\_\_\_\_