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AUTHORIZATION TO RELEASE OR REQUEST CONFIDENTIAL MEDICAL RECORDS

I hereby authorize:

Facility name _____

Address _____

City/state/ zip _____

To release information from the health records of:

Name _____

Date of birth ____ / ____ / ____ SSN: _____

Treatment dates: From _____ to _____

Day phone: _____

Information to be released:

_____ Copy of complete health records

_____ Billing info

_____ Lab results (specify) _____

_____ X-ray reports and/ or films (specify) _____

_____ Other (specify) _____

_____ Special instructions (specify) _____

Information is to e released to:

Facility name _____

Address _____

City/state/ zip _____

Phone/ Fax: _____

Purpose of disclosure: _____

This authorization is valid for ninety (90) days from the date signed. I understand that this consent can be revoked by me at any time, unless disclosure has already occurred in compliance with this consent.

Unless specifically excluded, this authorization includes release of *specialty protected records* requiring specific written consent. This includes referral to, diagnosis of and treatment for substance abuse, mental health conditions and sexually transmitted diseases including HIV (CFR 42, part 2). Certain records also require a minor’s consent. This applies to persons aged 13 to 18 for records pertaining to substance abuse and mental health records, or persons aged 14 to 18 for records pertaining to sexually transmitted diseases and HIV/AIDS.

I also understand that my records are protected under state and federal regulations regarding confidentiality and cannot be released or discussed without my written consent unless otherwise provided for in the regulations.

I understand that personal requests for medical records are subject to fees.

MOA: Paid? _____ Amount? _____ Date? _____ Method? _____

Patient/ guardian signature _____ Date: _____

Minor/ witness signature _____ Date: _____

Relationship to patient _____