Patient's Authorization for Release of Information

Name of Patient: ______________________________

Patient Birth date: ______________ Social Security Number: __________

Release of Information **From:** ______________________________
(Name and address)
____
____

Release of Information **To:** ______________________________
(Name and address)
____
____

The use or disclosure (as applicable) is for the purpose:

___ Continuing Medical Care ___ Insurance ___ Legal
___ SSI Disability Appeal ___ Research ___ At the request of the patient
___ Other ______________________________

Information to be released:

___ Consultation Reports ___ History and Physical ___ Lab(s) Reports
___ Operative/Procedure Reports ___ Radiology Reports ___ Pathology Reports
___ Specific ______________________________

Please indicate dates of treatment: ______________________________

Authorization for release of information protected by law

You must indicate authorization by initialing "Yes" on each line. If you choose not to have specific information sent, you must initial the "No" line.

AIDS related test results and information ___ Yes ___ No
Substance abuse information ___ Yes ___ No
Mental Health information ___ Yes ___ No

I fully understand that:

- The medical records and/or information that I have authorized to be disclosed hereunder are privileged, confidential and may only be disclosed with my authorization, except as required by law.
- Only such records and/or information reasonably believed necessary are to be released and disclosed.
- I may inspect and copy the records/information that is to be disclosed prior to sending.
- I understand that this consent is revocable at any time prior to the release of this information.
- This authorization is only valid for 120 days (6 months) from the date below.
- If I refuse to sign this authorization, my medical records/information will not be released.

______________________________ ______________
Signature of patient (18 or older) or Legal guardian Date