AUTHORIZATION TO RELEASE CLINICAL INFORMATION

Patient Name ____________________________________Maiden Name________________________MRN#_________

Date of Birth ________________________ Home Phone _____________________Cell/Work _____________________

Address ____ City/State/Zip _________________________________

Certification:
___ Self ___Authorized Representatives Name ___________________________Relationship________________

Email Address: ____

A) **I hereby authorize records FROM:**

Name ____

Address _______________________________

City/State/Zip ____

Ph __________________________________

C) **To be released TO:**

Name

Address _____________________________________

City/State/Zip

Ph _______________Fax _______________________

B) **For the purpose of:** _______________

___Continuity of Care/Transfer of Care

___ Self/Personal Copy ___ Litigation

___ Insurance ___ Disability

___ Work Comp

___ OTHER ____________________________

Date Range _________________ to

☐ Clinical Records ☐ Billing

☐ Operative Reports ☐ Lab/Path Reports

☐ Complete medical Record

☐ Other ____________________________

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 assure treatment. I understand that any disclosure of information carries with it the potential for an authorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that the information in my medial record may include information relating to sexuality transmitted disease, acquitted immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a 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 Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the renovation will not apply to my insurance company.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Date______________________

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Signature of patient/Parent/Guardian or Authorized Representative

Witness: ________________________________ Print Name: ________________________________ Date: ____________________

☐ Photo ID ☐ Legal Authorization Paperwork