

Authorization for Use and Disclosure of Medical Information

Patient Information: Print name: _____ Date of Birth: _____

SS# (Last 4 digits) _____ Maiden or prior last name: _____ Phone # _____

Please release my healthcare information from:

Please send my healthcare information to:

Name of Facility/Provider: _____

Name of designated recipient: _____

Tax ID: _____

Address: _____

Address: _____

City/State/Zip _____

City/State/Zip _____

Phone/Fax Number: _____

Phone/Fax Number: _____

Information to be released

Format: Paper Electronic (CD)

- | | |
|--|--|
| <input type="checkbox"/> Abstract of Health Information | <input type="checkbox"/> Records from _____ to _____ only |
| <input type="checkbox"/> The most recent 2 years of pertinent information (chart notes, labs, ultrasounds and special tests) | |
| <input type="checkbox"/> Complete Medical Record | |
| <input type="checkbox"/> Other (Specify): _____ | <input type="checkbox"/> Billing Records from _____ to _____ |

Purpose of Request:

- | | |
|---|---|
| <input type="checkbox"/> Continuing Care | <input type="checkbox"/> Workman's Comp. |
| <input type="checkbox"/> Personal use | <input type="checkbox"/> Disability Determination |
| <input type="checkbox"/> Other (Specify): _____ | |

Fees for Copying Medical Records

The following fees will apply:

The actual retrieval fee for medical records stored off-site \$ _____.

A base preparation fee of \$ _____ (waived for patient requests).

A charge of \$ _____ cents per photocopied page, and the actual cost of postage \$ _____.

These fees must be paid before your records can be released.

My Rights

I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing, and present to the office where my information is being released. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

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 to assure treatment. I understand that I may inspect or receive copies of the information to be used or disclosed, as provided in the Code of Federal Regulations (CFR 164.524). I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Patient Authorization

I understand that I may be charged the fees shown above for the copying of my medical records. I authorize _____ to release my medical records (including medical information related to the diagnosis or treatment for HIV testing, drug and alcohol, or a psychiatric condition) as specified above.

Signature: _____ Date: _____

(Patient, Guardian*, Authorized Representative*)

* Must provide documentation to prove authority to sign on behalf of the patient)

THIS AUTHORIZATION WILL EXPIRE 90 DAYS FROM THE DATE SIGNED