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*There may be a fee for copies of your medical records unless sent directly to another physician.

# AUTHORIZATION TO RELEASE MEDICAL INFORMATION

**[All sections must be completed]**

I hereby authorize _____

Address: _____

Phone: _____ Fax: _____

and its physicians, employees and agents to release or disclose to the below named recipient my medical records including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, sexually transmitted disease, or HIV/AIDS infection.

Patient Name:_____Date of Birth_____

I hereby authorize the release of medical records to: _____

Address:_____

Phone:_____Fax:_____

This request and authorization applies to:

_____ Medical records from [date]_____to [date]_____

_____ Specific records to be released [Labs, imaging reports, etc.]

_____

If you DO NOT WANT certain portions of your medical records released, please initial the box for the information you do not want released.

____Substance abuse ____Psychological or psychiatric treatment ____HIV/AIDS/STD

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent that they have acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I can refuse to sign this authorization and the above named office may not condition treatment on my signing of this authorization.

_____

Signature of Patient or Authorized Representative Date Signed

_____

Relationship to Patient