



**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

Patient Name \*Last: \_\_\_\_\_ \*First \_\_\_\_\_ MI: \_\_\_\_\_ Maiden Name: \_\_\_\_\_

\*Date of Birth: \_\_\_\_\_ Social Security Number: XXX-XX-\_\_\_\_\_

**\*Must be completed in order to release information**

<b>I hereby authorize the release of information concerning my treatment to:</b>	
*Facility Name: _____	
*Address: _____	
*City, State, ZIP _____	
—	
*Phone: _____	*Fax _____

\*Reason for request: \_\_\_\_\_

<b>*Information Requested:</b>	<b>*For the purpose of:</b>	<b>Cost of copies:</b>
Entire Record	Self	\$25 (pages 1-20)
Immunization Report Only	Physician	\$0.50 (each additional page)
Other (Specify) _____		(No charge to fax to physician)

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 individual or organization releasing information. I understand that the revocation will no apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization expires 180 days upon completion of this request.

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION, WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE, WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO, DISEASE SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, HUMAN IMMUNODEFICIENCY VIRUS (HIV), AND ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). I ALSO UNDERSTAND THAT PSYCHIATRIC (INCLUDING DEPRESSION) AND/OR CHEMICAL DEPENDENCY CONDITIONS AND/OR MEDICATIONS FOR THESE CONDITIONS MAY BE CONTAINED IN MY MEDICAL RECORDS AND CANNOT BE SEPARATED DURING PROCESS OF COMPLYING WITH MY REQUEST FOR SUCH INFORMATION.

\*Date \_\_\_\_\_ Signature of Patient: \_\_\_\_\_

<b>FOR OFFICE USE ONLY:</b>		
Date Received by Records Department: _____	Initials: _____	
Fax Number: _____	Secure Fax: YES / NO	
Date Request Completed: _____	# of pages copied: _____	Charges: \$ _____
Notes: _____		