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**Authorization to Release Medical Records**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Information to be Released From**

Name of facility or provider: \_\_\_\_\_

Address: \_\_\_\_\_

**Information to be Sent to**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

**Information to be Released (Please check)**

- 2 years of pertinent information (chart notes, labs, x-rays and any specialized testing).
- All Medical Records.
- Other (please specify) \_\_\_\_\_

**Purpose for which the disclosure is being made, please check.**

\_\_\_\_ Legal      \_\_\_\_ Insurance      \_\_\_\_ Provider      \_\_\_\_ Personal

**Patient Authorization**

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

**\*\*\*EXCLUDE the following information from the records released, please initial.**

\_\_\_\_ Drug/Alcohol abuse/treatment & diagnosis      \_\_\_\_ Sexually transmitted diseases  
\_\_\_\_ HIV/AIDS diagnosis/treatment/testing      \_\_\_\_ Mental illness or psychiatric diagnosis/treatment

**My Rights**

I understand I do not have to sign this authorization to obtain health care benefits (treatment, payment, or enrollment). I may revoke this authorization at any time in writing. To view the process for revocation of this authorization, please read the Privacy Notice to patients posted at the facility releasing your records. I understand that once the health information I have authorized is received by myself or receiving organization, it may be re-disclosed, at which time it may no longer be protected under privacy laws.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient, guardian or authorized representative).

This information will expire 90 days (about 3 months) from the date signed. Possible coping fee required.