Forms

Medical Records

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Medical Records Release Form

Authorization for Use or Disclosure of Protected Health Information

Patient's Information:

Last Name _____ First Name _____

Social Security Number _____ Date of Birth _____

Address _____

Phone Number _____

I request the medical records to be released to:

(Please initial your option)

Patient _____ Physician _____

Physician's Name _____

Address _____

Phone Number _____ Fax Number _____

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use of disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use of disclosure of this protected health information.

Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

Patient's Signature _____ Date _____

Patient's Name (please print) _____