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Authorization for Release of Medical Information

Patient_____ **Date of Birth**_____
(First) (Last) (MM/DD/YYYY)

I authorize the use or disclosure of the above-named patient's protected health information as described below.

I hereby authorize _____ to release the information.

For the purpose of: _____

Check Type of Record to be Released

☐ **Complete Health Record (or check for certain sections)**

☐ History and Physical
☐ Office Notes
☐ Operative Notes
☐ Imaging Reports
☐ Consultation Reports
☐ Procedure Notes
☐ Discharge Summary
☐ Other _____

I understand that information in my health record may include information relating to Confidential Information and may include mental health, alcohol and drug use information and I also authorize the release of this information.

I understand this authorization may be revoked by me at any time. This must be in writing to the Office Manager. This would not apply to information that has already been released prior to my written revocation.

I understand that information disclosed under this authorization may be subject to re-disclosure by the recipient of such information and the information may no longer be protected under the terms of this authorization or by federal privacy laws.

I understand I may refuse to sign the authorization.

Patient's Signature:_____Date:_____

Legal Guardian Signature:_____Date:_____

Relationship to Patient:_____