

Records Release Authorization

Name of Patient _____ DOB _____
Address _____ City _____ State ___ Zip _____

I HEREBY REQUEST AND AUTHORIZE THE FOLLOWING RELEASE OF INFORMATION

INFORMATION TO BE RELEASED

BY:

Name _____

Address _____

Phone _____

INFORMATION TO BE RELEASED

TO:

Name _____

Address _____

Phone _____

Information Requested:

X-rays Lab reports only

Other (please specify) _____

I UNDERSTAND THAT THE FOLLOWING RECORDS WILL **NOT** BE RELEASED UNLESS **INITIALED**. I CONSENT TO AND AUTHORIZE YOU TO RELEASE THE FOLLOWING RECORDS THAT I HAVE **INITIALED**.

Sexually transmitted disease

Substance abuse

HIV testing

Mental health

Patient signature

Date of signatures

Signature of parent or legal guardian (minor)

Relationship to the patient

Witness

This release expires after 90 days

I understand that I do not have to sign this authorization in order to receive health care benefits (treatment, payment or enrollment). I may revoke this in writing. To view the process for revoking this authorization, please read the privacy notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under the Privacy laws.