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RELEASE OF MEDICAL RECORDS AUTHORIZATION

PATIENT INFORMATION:

NAME ADDRESS CITY STATE ZIPCODE

DATE OF BIRTH PHONE NUMBER PREVIOUS NAME

AUTHORIZES:

NAME OF HEALTH CARE PROVIDER/PLAN/OTHER ADDRESS/CITY/STATE/ZIP

PHONE NUMBER FAX NUMBER

TO DISCLOSE TO:

NAME OF HEALTH CARE PROVIDER/PLAN/OTHER ADDRESS/CITY/STATE/ZIP

PHONE NUMBER FAX NUMBER

DATES OF INFORMATION TO BE DISCLOSED:

FROM:_____TO_____(IF LEFT BLANK, ONLY INFORMATION FROM THE PAST 2 YEARS WILL BE DISCLOSED)

INFORMATION TO BE DISCLOSED:

☐ ALL MEDICAL RECORDS RELATING TO (SPECIFY CONDITION, TREATMENT, ECT.)
☐ ALL BILLING RECORDS RELATED TO (SPECIFY CONDITION, TREATMENT, ECT.)
☐ SPECIFY RECORDS/INFORMATION AS FOLLOWS:

PURPOSE:

☐ FURTHER MEDICAL CARE ☐ LEGAL INVESTIGATION/ACTION ☐ INSURANCE ELIGIBILITY/BENEFITS
☐ PERSONAL ☐ OTHER: _____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: 1 am aware that 1 have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. I understand that I may be charged a fee for record copies. In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I also am aware that I may revoke this Authorization by notifying the disclosing medical records/health information department in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (l) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining i_nsurance coverage. I realize that the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law. This facility, its employees, offcers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. This Authorization will expire (1) year from the date signed.

SIGNATURE OF PATIENT/LEGAL REP:_____**DATE:** _____