



# Medical Record Release Form

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS: \_\_\_\_\_

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

**From/To (Please circle intended direction)**

Name:	Phone:	Fax:
Address:		

**From/To (Please circle intended direction)**

Name:	Phone:	Fax:
Address:		

**Purpose of Disclosure:**

<input type="checkbox"/> Continuity of care	<input type="checkbox"/> Insurance	<input type="checkbox"/> Legal	<input type="checkbox"/> Personal Use
<input type="checkbox"/> Transfer of care	<input type="checkbox"/> Other (please be specific)		

**Records to include:**

This authorization pertains to the disclosure of record types indicated below between following dates of service: From: _____ To: _____ OR <input type="checkbox"/> All records retained by this facility.			
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Lab Notes	<input type="checkbox"/> Immunization Records	<input type="checkbox"/> Operative Reports
<input type="checkbox"/> Hospital	<input type="checkbox"/> Imaging Records	<input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. \_\_\_\_\_ **Initials**

**Expiration:** This authorization shall expire 180 days from date of signature.  
 I understand that this authorization may be revoked by me at anytime except to the extent that action has been taken. I have the right to revoke this authorization at any time prior to 180 days by giving the healthcare provider written notice of revocation of this authorization. \_\_\_\_\_ **Initials**

**Re-disclosure:** I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996.

- I understand that:
- I have the right to refuse to sign this authorization
  - I have the right to receive a copy of this authorization
  - I have the right to inspect or copy the protected health information to be used or disclosed
  - Fees/charges will comply with all laws and regulation applicable to release of information

I have read the above and authorize the disclosure of the protected health information as stated.

\_\_\_\_\_ Date \_\_\_\_\_ Signature of Patient/Parent/Guardian \_\_\_\_\_ Relationship to patient