

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND INFORMATION**

I hereby authorize \_\_\_\_\_ (facility) to release medical information regarding: (Patient name) \_\_\_\_\_ (Birth date) \_\_\_\_\_ (Address) \_\_\_\_\_ (Telephone) \_\_\_\_\_

**1. NAME OF PERSON(s) or ORGANIZATION(s) TO WHOM DISCLOSURE IS TO BE MADE:**

Name/Organization: \_\_\_\_\_  
 Address: \_\_\_\_\_

**2. Specify Type of Information to be disclosed:**

\_\_\_\_\_ Inpatient record    \_\_\_\_\_ Outpatient record    \_\_\_\_\_ Other \_\_\_\_\_  
 \_\_\_\_\_ ER record    \_\_\_\_\_ Designated Record Set    \_\_\_\_\_ PMU record

3. Dates of service requested: \_\_\_\_\_

**4. The purpose for this disclosure:**

\_\_\_\_\_ Continuing medical treatment    \_\_\_\_\_ Legal    \_\_\_\_\_ Insurance    \_\_\_\_\_ Other

5. THIS FORM IS IN COMPLIANCE WITH THE HEALTH INSURANCE PORTABILITY and ACCOUNTABILITY ACT OF 1996, AND TITLE 42 OF THE CODE OF FEDERAL REGULATIONS, PART II. I UNDERSTAND THAT THESE RECORDS ARE PROTECTED UNDER FEDERAL AND STATE LAW AND CANNOT BE DISCLOSED WITHOUT MY WRITTEN AUTHORIZATION UNLESS OTHERWISE PROVIDED BY LAW. I FURTHER UNDERSTAND THAT THE SPECIFIC TYPE OF INFORMATION TO BE DISCLOSED MAY, IF APPLICABLE, INCLUDE: DIAGNOSIS, PROGNOSIS, AND TREATMENT FOR PHYSICAL AND/OR MENTAL ILLNESS, INCLUDING TREATMENT OF ALCOHOL OR SUBSTANCE ABUSE, ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS), AIDS-RELATED COMPLEX (ARC) OR HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION FOR ANY ADMISSIONS.

6. I UNDERSTAND that I have the right to revoke this authorization at any time unless the facility which is to make the disclosure of information has already done so in reliance upon my previous authorization. My authorization may be revoked by submitting a written and dated notice of revocation to the facility releasing this information. If not revoked, this authorization is valid until it expires 6 months from the date signed below or until the following date, event, or condition.

7. I HEREBY RELEASE THE ABOVE LISTED FACILITY, ITS EMPLOYEES, STAFF, AND AGENTS FROM ALL LEGAL RESPONSIBILITY OR LIABILITY THAT MAY ARISE FROM THE DISCLOSURE OF THE INFORMATION SET FORTH ABOVE RELATING TO MY MEDICAL RECORD.

8. I am 18 years of age or older    \_\_\_\_\_ yes    \_\_\_\_\_ no    I.D. Checked \_\_\_\_\_ (initials \_\_\_\_\_)

Date: \_\_\_\_\_ Patient: \_\_\_\_\_  
 Date: \_\_\_\_\_ Witness: \_\_\_\_\_

**FOR PATIENTS UNABLE TO AUTHORIZE:**

I, \_\_\_\_\_ hereby authorize the release of the above stated information and certify that I am the \_\_\_\_\_ Parent    \_\_\_\_\_ Guardian    \_\_\_\_\_ Next of Kin of the above named patient and that such patient is unable to authorize the release of the information because:  
 \_\_\_\_\_ he/she is a minor    \_\_\_\_\_ years of age    \_\_\_\_\_ Other \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
 Witnessed telephone consent on \_\_\_\_\_ (date) by \_\_\_\_\_ (patient/designee)  
 Witness: \_\_\_\_\_ and Witness \_\_\_\_\_

3-Hole 1/4 4 1/4 c-to-c

