MEDICAL RECORDS RELEASE

Patient Date of Birth _____/_____/_____ Patient SSN: _____

I, _____, hereby consent to the release of my medical records.
(Please print patient name)

I understand my records will be release TO / FROM:

Person / Entity _____

Address _____

Phone Number _____ Fax Number _____

Records that will be released are: (please check all that apply)

_____ Entire chart including clinical notes, labs, prescriptions, images, phone call records, etc

_____ Notes for all dates of services

_____ Notes for a specific date of service: _____

_____ Specific report _____

_____ Billing information _____

_____ Other _____

I understand and acknowledge that if none of the above options are checked then my complete records will be disclosed. I understand that this authorization will remain in force until revoked by me in writing.

Specific Authorization for HIV / AIDS Testing, Drug and Alcohol, and Mental Health Records

I acknowledge that the records to be released MAY include material that is protected by Federal Regulation 42 CFR, part 2 and is applicable to the above. My signature below authorizes the release of information. Check here to suppress disclosure of this type of information: ( )

I hereby acknowledge the above information and authorize the release of said medical records and/or billing information to the above referenced person/entity. I understand that these records are protected by law and cannot be disclosed without my permission.

_____ _____
Signature of Patient (or other responsible person) Date

_____ _____
Relationship (if not the patient) Signature of Witness

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