AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ its employees and agents to disclose and discuss the following Health Care information

**Information to be included: (check appropriate boxes)**

**\_\_** Discharge Summary **\_\_** History & Physical **\_\_** Emergency Department Records

**\_\_** Lab Reports **\_\_** Urine Screening **\_\_** Progress/Office Notes

**\_\_** Immunization/Vaccination Records **\_\_** Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  **I DO** [ ]  **I DO NOT** Authorizerelease of information related to**:**

**\_\_** AIDS/HIV **\_\_** Psychiatric Care/Psychosocial assessment **\_\_** Mental Health Notes

**\_\_** Alcohol Use **\_\_** Substance Use

**Dates of Service to be included: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ through \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Information to be released to: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Fax# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Information will be released by:**

**\_\_** Mail to address above **\_\_** Fax to Health Care Provider # listed above

 **\_\_** Transfer electronically via EMR (electronic medical records) **\_\_** Verbal release

**\_\_** Transfer electronically via email address above.

**I UNDERSTAND THAT:**

* I may revoke this Authorization at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically 360 days from the date signed.
* The revocation will not apply to information that has already been released in response to this Authorization.
* I must revoke this Authorization in writing.
* I can refuse to disclose all or part of the information in my treatment records.
* I can refuse to sign this Authorization.
* My treatment/care may not be conditioned upon my signing this Authorization.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient’s representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: ­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: **\_\_ Parent \_\_ Guardian \_\_ Power of Attorney \_\_ Other** \_\_\_\_\_\_\_\_\_\_