

Medical Release for Records

To disclose and/or receive copies of information to the following Physician:

Physician Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Including the diagnosis and records of any treatment or examination rendered to me during the period of time _____ (date) to _____ (date).

Patients Name (print) _____

Date of Birth _____

Specifically, the following reports will be included:

_____ X-rays _____ X-ray Reports _____ Laboratory/Pathology Reports _____ Progress Notes

_____ Other (specify) _____

_____ (initials) I ___ DO or ___ DO NOT consent to release of information relating to psychiatric or psychological testing or treatment, biofeedback training, alcohol and/or drug abuse diagnosis, prognosis and treatment and/or HIV(AIDS) testing and/or results or such disclosure shall be limited to the following specific types of information: _____

Purpose of disclosure: _____ Medical Care _____ Attorney _____ Insurance _____ Other

This authorization shall be valid for 120 days from the date of signature. The patient can revoke the authorization in writing at any time prior to the expiration date. The patient agrees that a photocopy of this authorization may be considered valid. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer to protect. I hereby release and hold harmless the above named facility and its parent company from all liability and damage resulting from the lawful release of my Protected Health Information.

Signature of Patient or Authorized legal representative

Date

Relationship to Patient

Witness Signature and Date

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