Authorization for Disclosure of Health Information

Patient Name: _____

Date of Birth: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

I am writing to request copies of my medical records from:

My treatment dates are from: _____ to: _____

Fax my records to:

Name of provider: _____

Fax Number: _____ Phone Number: _____

The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

_____ History and physical / Progress Report	_____ Consultation reports
_____ Lab result	_____ Discharge summary
_____ Imaging report	Other (please specify:

- I acknowledge and hereby consent to such that the released information may contain alcohol, drug abuse, psychiatric, HIV Testing, HIV results, or AIDS information. **Initial Here** _____.
- I also hereby authorize that a photocopy of this authorization be accepted with the same authority as the original. The information disclosed will be used for the purpose of continuity of care.
- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____.

_____

Signature of patient or legal representative

Print Name: _____ Time & Date:_____