Medical Release of Information

Authorization Form

PATIENT INFORMATION

Patient Name: ___________________________________ Date of Birth_____/_____/______

Address: _____________________________ Phone: ______________________

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INFORMATION TO BE RELEASED

Date(s) of Service From _____/_____/_____ to _____/_____/_____

Description of records to be released:

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Information to be released to: Name/Clinic: ____

Address: ____

Phone: ____________________ Fax: ___________________

______ *(initial)* I authorize the release of any and all medical and billing information pertaining to me to the named individual/clinic above. This includes but is not limited to the diagnosis, examination rendered to me, claims information, medical history, imaging, and test results. I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed. I understand the information disclosed to any of the above recipient is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient.

______ *(initial)* I understand this release of information will remain in effect until terminated by me in writing or one year whichever comes first.

______ *(initial)* I understand that this authorization does not include any medical records regarding HIV and/or mental health information and that a separate authorization is needed for such records.

Patient Signature: ____ Date: ______________

Printed Name: _____________________________________

--*Office Use Only*--

Witness: __________________________Printed:__________________________ Date:___________