AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize ____and its physicians, employees, and agents to release or disclose to the below-named recipient all of my medical records including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, sexually transmitted disease, or HIV/AIDS infection, unless specifically excluded.

Patient Name: ____Date of Birth: ____________________________

I hereby authorize the release of medical records to: ____
____

Purpose of disclosure: ____

The authorization will expire on: ____
Date or Event may not exceed one year

This request and authorization applies to:

_______ All medical records, unless indicated as an Exception, below.

_______ Healthcare information relating to the following treatment, condition, or dates of treatment:
____

_______ Specific records to be released (e.g., labs, imaging reports, other):
____

EXCEPTION. If you do NOT want certain portions of your medical records released, please initial the box for the information you do not want released.

______Substance abuse ______ Psychological or psychiatric treatment ______HIV/AIDS/STD

I understand I have a right to revoke (withdraw or cancel) this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization and that any signed copy may be considered as valid as the original. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

Signature of Patient: ____ Date: ____________________________

Name of Personal Representative (if applicable): _____________________Relationship: _____________________

Signature of Personal Representative: ______________________________ Date: ____________________________