



AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____ Medical Record Number: _____

Date of Birth: _____ Home Phone: _____ Cell/Work Phone: _____

Address: _____ City/State/Zip: _____

Email Address: _____

I authorize disclosure of my records **FROM:**

Name _____

Address _____

City/State/Zip _____

Phone # _____ Fax # _____

I authorize disclosure **TO:**

Name _____

Address _____

City/State/Zip _____

Phone # _____ Fax # _____

Purpose of Disclosure: Continuity of Care Personal Use Legal Other _____

Records will be delivered by secure portal or email unless notated here: _____

Date Range: _____ to _____

Progress Notes Lab/ Pathology Reports Medication List Radiology Reports

Other _____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making the disclosure.

In addition, I authorize the disclosure of any information related to the following (initial, if it is OK to release this information):

- _____ Sexually transmitted disease
- _____ Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV)
- _____ Behavioral or mental health services
- _____ Substance Use Disorder Information/ Alcohol and/or drug treatment records
- _____ Medication-Assisted Treatment (MAT)

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand that this authorization will expire one year from the above date unless I specify a date. I have read the information provided on this release form and do hereby acknowledge that I fully understand the terms and conditions of this authorization.

Signature of Patient/Parent/Guardian or Authorized Representative

Date

Expiration Date: _____
Expires one year from the date signed unless otherwise specified above.