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RECORDS RELEASE AUTHORIZATION

I, _____, hereby request and authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary.

Patient Name: _____

Address: _____

_____

Phone: _____ Date of Birth: _____/_____/_____

RECORDS RELEASED FROM:

_____

_____

_____

_____

RECORDS RELEASED TO:

_____

_____

_____

_____

Please check one: ☐ - Mail records ☐ - I will pick up records ☐ - Fax records

INFORMATION TO BE DISCLOSED
(Check all that apply)

_____ Entire medical record
_____ Office reports
_____ Operative reports
_____ Medical records for specific period: _____
_____ Other (please specify): _____

_____ Laboratory reports
_____ X-Ray reports
_____ Billing information

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law. By signing below, I represent and warrant that I have authorized to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____
Signature of patient Date

_____ _____
Signature of legal representative Representative's authority to sign
(Parent, Guardian, Power of Attorney, etc.)

Please note: There is a fee associated with copying of medical records.
If you have questions, please ask at the Business Office.