Today’s Date \_\_\_/\_\_\_/\_\_\_

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This signed authorization allows the healthcare provider(s) named below to release confidential

medical information and records for the named individual. *Note: Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substances abuse have*

*special rules that require specific authorization.*

I hereby request the health records/information of:

Patient Name: .

Date of Birth: .

Patient Phone Number: .

Medical Provider/Office **Providing** Information:

Name:

Address:

Phone Number: Fax:

To release information regarding my medical history, including illnesses/conditions, medications, treatment, procedures, and laboratory data including pathology, labs, and/or imaging, correspondence

and/or medical records by means of mail, fax or other electronic methods to:

Medical Provider/Office **Receiving** Information:

Name:

Address:

Phone Number: Fax:

This authorization is:

[ ] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)

[ ] Limited to the following medical information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DURATION This authorization shall be effective immediately and remain in effect until \_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE ALLOW 3 BUSINESS DAYS FOR PROCESSING.

I have been advised of my right to receive a copy of this authorization.

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_

Relationship (*if other than Patient )* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_