Authorization for Release of Medical Information

MRN _____

I hereby authorize the release of information from the medical record of:

Patient Name _____ Date of Birth _____

Social Security # _____ (optional) Daytime Phone # _____ (optional)

Information Released TO:	FROM:
_____	_____
_____	_____
_____	_____

Please Release the Following:

_____ Problem List	_____ X-Ray Reports
_____ Progress Notes	_____ X-Ray Films
_____ History / Physical Exam	_____ EKG Reports
_____ Lab Reports	_____ Other Diagnostic Reports (Specify) _____
_____ Immunizations	_____ Other (Specify)

Including information (if applicable) pertaining to:

_____ Mental Health _____ Drug / Alcohol _____ HIV / AIDS _____ Communicable Treatment

Purpose or Need for Disclosure:

_____ Continued Patient Care	_____ Personal Use
_____ Attorney / Legal	_____ Insurance Claim / Application
_____ Disability Determination	_____ Other (Specify) _____

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it. This consent will expire 90 days after the date of my signature unless otherwise specified.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Relationship to Patient Witness

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries.

I will not hold liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Relationship to Patient Witness

Date request completed _____ # pages copied _____ Reviewed only _____

Charges $ _____ Cash _____ Check # _____ Initials _____