Authorization to Release/Obtain Medical Records

I authorize a copy of the medical information for:

Full Name_____SS#:_____ DOB: _____

To be released to:	To be released from:

Name: _____   _____
Address: _____   _____
City, State, Zip: _____   _____
Phone/Fax: _____   _____

By initialing the spaces below, I specifically authorize the release of the following medical records, if such exist:
(   ) All records
(   ) Laboratory/pathology reports
(   ) Radiology/MRI/CT/Ultrasound reports
(   ) Immunization Records
(   ) Records during a specific time frame of _____ to _____ (dates)
(   ) Other _____

__Note__: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, mental health information, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal and/or state 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, payment, eligibility for benefits unless allowed by law. I understand this authorization may be revoked in writing at any time, except to the extent that action had been taken in reliance on the authorization. Unless otherwise revoked, this authorization will expire 1 year from date of signature.

_____   _____
Signature of patient or person authorized by law and relationship to patient   Date

__Charges for medical records__: $25 flat rate.

Payment method: Credit Card / Check / Cash   Amount: $_____

For office use only
Mailed/Faxed (date) _____/_____/_____ (initial) _____
Left at front desk for pick-up (date) _____/_____/_____ (initial) _____