**Authorization for Release of Medical Information**

Patient Full Name___________________________________ DOB___/___/___ SSN___________________

Previous/Other Name (if different than listed above)____________________________________________

| **This will authorize:** | **To release to:** |
|---|---|
| Practice Name:________________________________ | Practice Name:_____________________________ |
| Address:_____________________________________ | Address:___________________________________ |
| City, State, Zip:________________________________ | City, State, Zip:______________________________ |
| Phone: _____________________________________ | Phone:____________________________________ |
| | Fax: ______________________________________ |

**Medical Records Requested From (dates): ____________________ to ________________________**

**--OR--**

**List specific records requested (labs, imaging, progress notes, etc.)___________________________________**

**(if this section is left blank, a summary of records from the last 2 years will be provided)**

**Reason for release:______________________________________________________________________**

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION
PROTECTED BY STATE OR FEDERAL LAW

I specifically authorize the release of data and information relating to (check yes or no):

| YES | NO | |
|---|---|---|
| ___ | ___ | Substance abuse (alcohol/drug abuse) |
| ___ | ___ | Mental health/depression (includes psychological testing) |
| ___ | ___ | HIV-related information (AIDS related testing) |

This consent may be revoked at any time by notifying the above named provider of information in writing. This release will expire 1 year after date on this form, unless another date is specified here: ________________________________, in which case release will expire on specified date. Any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Disclosed information may be reviewed by contacting the provider of information.

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations. I understand I do not have to sign this authorization in order to obtain health care services.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. This facility has contracted with HealthPort to make copies. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice.

___________________________________________

Signature of patient or authorized representative

Date ___/___/___