GENERAL MEDICAL RECORDS RELEASE AND AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please complete the following information:

Patient Name: _____
Address: _____
_____
Phone: _____(Home) _____(Cell) _____(Work)

Date of Birth:_____/_____/_____

I authorize the custodian of records of: _____
or other person/entity (specifically describe) to disclose/release the following information*
(check all that apply):

❑ Entire medical record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records and records sent to you by other healthcare providers.
❑ Laboratory/pathology records
❑ X-ray/radiology records
❑ Billing records
❑ Abstract/Summary
❑ Pharmacy/prescription records
❑ Other (describe specifically): _____

Note: If these records contain any information from previous providers, you are hereby authorizing disclosure of this information.

Disclosure of information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease must be specifically authorized in the box below.

My initials and signature below authorize the release of healthcare information relating to testing, diagnosis or treatment for:

_____ HIV/AIDS
_____ Sexually Transmitted Diseases
_____ Reproductive Care (minors only)
_____ Mental Health
_____ Alcohol/Drug Abuse

MINORS—A minor patient's signature is required in order to release the following information (1) conditions relating to the minor's reproductive care including, but not limited to, contraception, pregnancy and pregnancy termination, sterilization, and sexually transmitted diseases (age 14 and older), (2) alcohol and/or drug abuse (age 13 and older), and (3) mental health conditions (age 13 and older).

_____	_____	_____
Date	Signature of patient or patient's authorized representative	Relationship to patient if not patient

These records are for services provided on the following date(s): _____

Please send the records listed above to (use additional sheets if necessary):

Name: _____ Name: _____
Address: _____ Address: _____
_____ _____
Phone: _____ Phone: _____
Fax: _____ Fax: _____

The information may be used/disclosed for each of the following purposes:

❑ At my request (*only the patient can check this box*)
❑ For my healthcare
❑ For payment/insurance
❑ For employment purposes
❑ Other: _____

This authorization shall expire no later than: ___/___/___ or upon the following event _____ (whichever is sooner), and may not be valid for greater than one year from the date of signature.

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 authority 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 (or patient's personal representative)	Date
_____	_____
Printed name of patient representative	Representative's authority to sign for patient *(i.e., parent,guardian, power of attorney for healthcare, executor)*

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