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Authorization for Release of Medical Records

Please complete, sign and return this form to request transfer of your medical records.
This form must be completely filled out to be considered valid. Please print or type.

Patient Name: _____ Date of Birth: _____

Street Address: _____

City/State/Zip: _____ Daytime Phone: (_____) _____ - _____

I Authorize: **Name of Doctor**: _____ Specialty: _____

Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

City/State/Zip: _____

to release information from the medical record of the above-named person

To: **Name of Doctor**: _____ Specialty: _____

Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

City/State/Zip: _____

We send the last 3 years of records as "All" records unless otherwise indicated below. Send:

☐ All records for the past 3 years; or ☐ Records from (dates) _____ to _____
☐ Specific labs: _____ ☐ Specific imaging reports: _____
☐ Other (explain): _____

For the purposes of: ☐ Continuation of Care ☐ Patient Request ☐ Transfer ☐ Life Insurance
☐ Legal ☐ Social Security ☐ Other _____

I understand that I am authorizing the release of all medical information from my chart except:
☐ HIV/AIDS (or related testing) ☐ Mental Health ☐ Chemical Dependency (Drugs/Alcohol)

I understand that information released may include records released from other physicians' offices, hospitals or other facilities.

This authorization is valid for 180 days from the date signed or until _____, whichever is sooner, and may be revoked, in writing, except to the extent that information has already been released. We will not condition treatment or payment based upon this Authorization or Revocation of Authorization unless otherwise allowed by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected.

_____	_____	_____
Signature of Patient or Legal Guardian	Date	Relationship to Patient, if Not the Patient