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Authorization for Use or Disclosure of Protected Health Information

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/Entity**: _____ Specialty: _____

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

City/State/Zip: _____

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

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

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

City/State/Zip: _____

Specific records to be released:

☐ Most recent; or ☐ Specific date range: _____ to _____

☐ Specific labs if any: _____ ☐ Specific imaging reports if any: _____

☐ Other if any(explain): _____

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

Requested format: ☐ Paper copy ☐ Fax ☐ Other: _____

I understand that the information released may include medical information related to treatment of alcohol, substance abuse, mental health, and/or HIV/AIDS, if applicable.

I understand that the 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. I understand that if the entity that receives the information is not a healthcare provider or health plan covered by Federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

_____	_____	_____
Signature of Patient or Legal Guardian	Date/Time	Relationship to Patient, if Not the Patient (written proof may be required)