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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: __X_____ DOB: _X_____
Address: __X_____ Phone: _X_____
City: _X_____ State: _X_____ Zip Code: __X_____

I authorize the release of the following protected health information:
Name of Physician/Address _____
____ Office Notes ___Lab Reports ____ Other: _____: _____ Paper Copy __X___ Electronic Copy

The purpose for this request to release medical information is:
___X__ Medical Care/Treatment _____ Insurance _____ Other (specify_____

Send my medical information to: Name: _____
Complete Address: _____
_____

I understand that:

- By signing this form, I am authorizing the use or disclosure of protected health information as indicated above.
- I may refuse to sign this authorization, which will not affect my treatment or payment for health care.
- I may revoke this authorization at any time before the information I have requested is released by providing written notice of revocation as specified in the Notice of Privacy Practices.
- If the receiving party is not subject to medical records privacy laws, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law. This office shall not be held liable for any consequences resulting from re-disclosure.
- A copy of this signed form will be provided to me upon my request.
- This office may charge an administrative fee to cover the cost of labor, copying, and/or postage. This office will inform me of any charges and arrange for payment.
- This authorization expires on ____/____/_____ (if date not completed/one year after signed).

__X_____ _____
patient/representative signature date

If the patient listed above is a minor or is unable to sign, and you are a parent, legal guardian, or personal representative signing on behalf of this patient, please sign above and complete the following:

_____ _____
print name relationship to patient