

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

\_\_\_\_\_  
Print Patient's Full Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
City/State/Zip Code

\_\_\_\_\_  
Home Phone Number

\_\_\_\_\_  
Discharge Summary  
\_\_\_\_\_  
History & Physical  
\_\_\_\_\_  
Progress Notes

\_\_\_\_\_  
Pathology Reports  
\_\_\_\_\_  
Laboratory Reports  
\_\_\_\_\_  
Radiology Reports

\_\_\_\_\_  
Emergency Reports  
\_\_\_\_\_  
Other  
\_\_\_\_\_

Please list your preferred method of contact to receive practice notification regarding your health:

\_\_\_\_\_  
Text message, preferred number: \_\_\_\_\_  
\_\_\_\_\_  
Email, preferred email: \_\_\_\_\_  
\_\_\_\_\_  
Voicemail, preferred telephone number: \_\_\_\_\_

\_\_\_\_\_  
I do \_\_\_\_\_ I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

I HEREBY AUTHORIZE THE RELEASE OF RECORDS FROM: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PLEASE RELEASE INFORMATION TO: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PURPOSE OF DISCLOSURE:  
\_\_\_\_\_  
Referral to Specialist      \_\_\_\_\_ Insurance      \_\_\_\_\_ Workers Comp      \_\_\_\_\_ Change of Doctor/Provider  
\_\_\_\_\_  
Legal Investigation      \_\_\_\_\_ Personal      \_\_\_\_\_ Continuing Care      \_\_\_\_\_ Disability Determination  
\_\_\_\_\_  
Other (please specify) \_\_\_\_\_

Note: There may be a charge for a personal copy or the permanent transfer of your records as follows: A \$10.00 base fee, \$0.50 per page for pages 1-50, then \$0.25 for any pages over 50.

**Please provide the best telephone number in the event we need to contact you (home, work or cell):**  
(\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_.

I hereby authorize disclosure of the health information for the above-named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. 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 regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

\_\_\_\_\_  
**Signature of Individual, Guardian or Legal Representative**

\_\_\_\_\_  
**Date**