



PATIENT REQUEST FOR MEDICAL RECORDS RELEASE

I hereby authorize the release and disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

I authorize _____ (hospital/physician) to release the following information from my medical records to _____ (hospital/physician).

Patient Name: _____ Date of birth: _____

Address: _____

Covering the period of health care from _____ (date) to _____ (date).

This authorization will stay in effect for 30 days from the date of my signature below.

Patient Signature: _____ Date: _____

Information to be released:

_____ Complete health record(s)

OR

Select from the following (check as many as apply):

_____ History & Physical Examination

_____ Follow-up Office Visit Reports

_____ X-ray reports

_____ Photographs, videotapes, digital or other images

_____ Consultation Reports

_____ Laboratory Tests

_____ AIDS or HIV infection

_____ Progress Notes

_____ Mental health care or services

_____ Treatment for alcohol and/or drug abuse

_____ Other: _____