AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

This authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization.

I authorize _____ to release a copy of the medical information
(Name of hospital/health care provider)

for _____ To _____
(Name of Patient) (Name & Address of recipient &/or **Department**)

_____.

The information will be used on my behalf for the following purpose(s):_____.

____All hospital records (including nursing records & progress notes)

____Transcribed Hospital reports

____Medical records needed for continuity of care

____Most recent 5 year history

____Laboratory reports

____Pathology reports

____Diagnostic imaging reports

____Physical Therapy records

____Emergency/Urgent care records

____Billing statement

____Clinician office chart notes

____Dental records

____Other (list below)
_____

____Please send the entire medical record (all information) to the above named recipient. The recipient understands This record may be voluminous and agrees to pay all reasonable charges associated with providing this record.

____* HIV/AIDS related records

____* Mental Health information

____* Genetic testing information

(* These items must be initialed to be included in other documents)

____** Drug/alcohol diagnosis, treatment or referral information: _____

_____.

(** Federal regulation, 42 CFR part 2, requires a description of how much and what kind of information is to be disclosed)

____This authorization is limited to the following treatment: _____.

____This authorization is limited to the following time period: _____.

____This authorization is limited to a worker's compensation claim for injuries of _____ (date).

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

_____ _____
(Date) (Signature of patient)

_____ _____
(Date) (Signature of person authorized by law)

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