**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

I authorize and request:

| | | |
|---|---|---|
| Name of Facility | | |
| Address | | |
| City | State | ZIp |
| Phone# | Fax# | |

And its authorized agents and employees to release the following information from the health records of:

| | | |
|---|---|---|
| Patient Name- Last, First, MI | | |
| Street Address | Telephone # | |
| City | State | Zip |
| DOB | SSN | |

The information is to be released to:

| | | |
|---|---|---|
| Name (i.e...insurance Co., Lawyer, Physician, Self…) | | |
| Street Address | | |
| | | |
| Phone# | Fax# | |

Information to be released: (Check applicable categories)

[ ]Discharge Summary [ ]History and Physical Exam [ ]Operative Report
[ ]Lab/Pathology [ ]X-Ray Reports [ ]EKG Reports

Other: _____

Purpose or Need for Disclosure: (Check applicable categories)

[ ]Further Medical Care [ ]Payment of Insurance Claim [ ]Application for Insurance
[ ]Legal Investigation [ ]Personal [ ]School Disability
[ ]Academics [ ]Other: _____

I understand that this authorization will automatically expire in six months from this date but may be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent.

I understand that my medical records may contain information that indicates that I have a communicable or non-communicable venereal disease which may include, but is not limited to, disease such as Hepatitis, Syphilis, Gonorrhea or the Human Immunodeficiency virus: also known as Acquired Immune Deficiency Syndrome (AIDS).

Information released may include alcohol and drug abuse records protected under the Code of Federal Regulations and psychiatric records, if any. Re-disclosure of this information by the recipient is prohibited without specific authorization. I waive all rights and privileges allowed by law relating to disclosure of confidential information relating to this authorization and release the facility, its agents and employees from legal responsibility arising from the release of this information.

_____ _____

Signature of Patient or Person Authorized to Sign for Patient Date

_____ _____

Relationship to Patient Witness