

RELEASE OF INFORMATION - Patient Authorization

1) Patient Name (Print) _____

Date of Birth _____ S.S. # _____

Maiden or Previous Names _____

Patient # (Office Use) _____

COMPLETE ADDRESSES PLEASE

2) I AUTHORIZE INFO TO BE RELEASED FROM _____

RELEASE INFO TO: _____

NAME _____

NAME _____

ADDRESS _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

CITY _____ STATE _____ ZIP CODE _____

PHONE, or _____

PHONE, or _____

FAX # _____

FAX # _____

*** Yes ___ No ___ I do authorize the release of other providers records found in my record.

3) Medical Information required _____

Dates Needed _____

Doctor(s) _____

- Office Visits
- X-ray Reports
- Lab Reports
- Surgery Reports
- Other _____

4) Purpose of Release _____

- Transferring Medical care
- Referral
- Moving
- Other _____
- Insurance
- 2nd Opinion
- Legal

5) _____

Signature of Patient or Legal Guardian
(Patients over 18 must sign own release)

Date: _____

Relationship, if not patient _____

6) _____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW * See Back**

I specifically authorize the release of information relating to: *Please Mark (Yes, No, NA - Not Applicable)*

- 1. _____ **Substance abuse**
(Alcohol or drug)
- 2. _____ **Mental Health**
(Includes Psychological testing)
- 3. _____ **HIV related Info**

Signature of Patient or Legal Guardian _____

Date _____

In order for the above info to be released, you must **SIGN HERE** and **RESPOND ON** the appropriate lines.

NOTE: This authorization will automatically expire 1 year from the date of signature. This consent can be revoked at any time by notifying the above named provider of the information.

Redisclosure of this info without further written consent is prohibited.

Office Use Only
Copies Completed by: _____ Date _____