

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION
~ ADULT ~

This release expires 90 days from the date of signature or upon patient's written request

Patient's Name: _____
Date of Birth: _____ Social Security Number: _____
Previous Name Under Which Records May Be Filed: _____
Patient's Current Address: _____
Patient's New Address if Moving: _____
Patient's Current Phone Number: _____ Patient's New Phone Number if Moving: _____

I specifically authorize any current employee of:

Name of Doctor/Facility: _____
Address: _____

to release my medical records as described on this form for the following reason _____.

I understand that when the information is released, it may be subject to re-disclosure by the recipient and may no longer be protected Personal Health Information (PHI).

Please release my Medical Records to:

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____

Please initial the appropriate box to indicate which records you wish to be released and be charged for:

- _____ Records generated in this office only (**not including** x-rays, fetal monitor strips, electrocardiograms, old records, outside lab results). If no box is initialed, this option will be used.
- _____ Records generated in this office only (**including** x-rays, fetal monitor strips, electrocardiograms, old records, outside lab results, which may incur an additional charge).
- _____ Other: _____
(specific dates of treatment or specific parts of the record).

Patient Signature _____ (patients 18 years and older must sign for themselves)	Date _____
OR	
Signature of Legal Representative _____ Relationship to Patient _____	Date _____

**** PLEASE READ BELOW SECTION ****

I understand that a separate, expressed consent is required to release sensitive healthcare information in my record, and I specifically request that _____ (name of physician or facility) release any medical information pertaining to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use.	
Patient Signature _____ (patients 18 years and older must sign for themselves)	Date _____
OR	
Signature of Legal Representative _____ Relationship to Patient _____	Date _____