AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name:_____ Date of Birth:_____

Address:_____City/Zip Code:_____

Home Phone:_____ Cell Phone:_____

Above listed patient authorizes the following facility to make records disclosure:

Facility name:_____

Address:_____City/Zip Code:_____

Phone Number:_____ Fax Number:_____

Dates and Type of Information to Disclose:

Dates:_____ Purpose of Disclosure:_____

Information Requested: Medical Records Billing Records

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information for the dates stated above.

Above listed patient authorizes medical/billing information to be disclosed to the following:

Facility name:_____

Address:_____City/Zip Code:_____

Phone Number:_____ Fax Number:_____

Release records by: Fax Mail In person

I understand I may revoke this authorization at any time but I must do so in writing and present at the releasing facility. I understand that the revocation will not apply to any past information that was previously released. Any revocation will not apply to my insurance company or referring physician. I understand that authorizing disclosure of health information is voluntary. I understand that I may inspect or obtain a copy of the information to be disclosed. I understand that any disclosure of information carries the risk of unauthorized redisclosure and the information may not be protected by federal confidentiality rules. This authorization will expire 1 year after the date it is signed.

Signature of Patient/Parent/Guardian:_____ Date:_____

Printed Name of Authorized Representative:_____