



AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization. **There will be a \$15.00 charge for all records released to patients.**

AUTHORIZATION

I hereby authorize:

Name (where you are requesting records FROM)

Address

City

State

Zip Code

Telephone Number

Fax Number

to release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records by means of mail, fax or other electronic methods to:

Name (where you want your records SENT TO)

Address

City

State

Zip Code

Telephone Number

Fax Number

The medical information/records will be used for the following purpose: _____

This authorization is:
 Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)
 Limited to the following medical information: _____

I also consent to the specific release of the following records:
Drug/Alcohol/Substance Abuse _____ (initial) Tests for Antibodies to HIV _____ (initial)
Psychiatric/Mental Health _____ (initial) HIV Diagnosis/Treatment _____ (initial)

DURATION This authorization shall be effective immediately and remain in effect until _____ Date _____.

RESTRICTIONS
Permission for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy or facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

TIME Copies will be released within fifteen (15) days after receiving a written request.

Signature of patient or legal/personal representative

Relationship if other than patient

Patient's Name (PRINT)

Date

Patient's Social Security Number

Patient's Date of Birth

Witness Name

Witness Signature