**AUTHTORIZATION FOR RELEASE OF MEDICAL INFORMATION**

Please complete this form completely. Please print.

Your medial record cannot be released until this form is completed and signed by the patient (if 18 years or older) or legal guardian. If the patient or legal guardian requests a personal copy of medical records, a copying charge will be applied. Please consult the medical office sending the records for more information.

**Step 1: Information about you**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Step 2: Records Requested From**

I hereby Authorize: Name of Person/Facility \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_

 Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Step 3: Records to Disclose to**

Name of Person/Facility \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_

 Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Step 4: Information you are Requesting**

\_\_\_\_\_\_ All Records

\_\_\_\_\_\_ Records for dates from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Only

\_\_\_\_\_\_ Other Records (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Step 5: Authorization to release any of the following sensitive information or medical records. I authorize the release of the following sensitive information, which may be in my chart:**

**MUST CHECK YES OR NO FOR EACH**

Abortion: \_\_\_YES \_\_\_NO AIDS/ARC: \_\_\_YES \_\_\_NO

HIV testing: \_\_\_YES \_\_\_NO Mental Health Visits: \_\_\_YES \_\_\_NO

Eating Disorders: \_\_\_YES \_\_\_NO Alcohol/Drug Abuse: \_\_\_YES \_\_\_NO

Sexual Assault/Rape: \_\_\_YES \_\_\_NO STD’s: \_\_\_YES \_\_\_NO

**Step 6: Your Signature and Authorization**

This authorization is for the release of medical records as specified in Steps 4 and 5. This request is valid for 90 days and may be revoked at any time by written request.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Patient’s Signature (18yrs or older) Parent/Guardian Signature Date