

REQUEST FOR RELEASE OF MEDICAL INFORMATION

Print Patient's Full Name

Birth date (mmddyyyy)

Street Address

Social Security Number

City, State, Zip Code

Phone (Home)

At the request of the individual, I _____ do hereby authorize _____
to release: (Patients Name) (Name of Facility)

Dates of _____

- | | | |
|---|---|--|
| <input type="checkbox"/> DISCHARGE SUMMARY | <input type="checkbox"/> PATHOLOGY REPORTS | <input type="checkbox"/> EMERGENCY REPORTS |
| <input type="checkbox"/> HISTORY & PHYSICAL | <input type="checkbox"/> LABORATORY REPORTS | <input type="checkbox"/> OPERATIVE NOTES |
| <input type="checkbox"/> PROGRESS NOTES | <input type="checkbox"/> RADIOLOGY REPORTS | <input type="checkbox"/> ECG/EEG/CARDIC CATH |
| <input type="checkbox"/> ALL RECORDS | <input type="checkbox"/> OTHER _____ | |

I do I do not authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO:

Name of Company/ Agency/Facility/Person

Phone

Street Address

Fax

City, State, Zip

PURPOSE OF DISCLOSURE:

- | | | | |
|---|------------------------------------|---|---|
| <input type="checkbox"/> REFERRAL TO SPECIALIST | <input type="checkbox"/> INSURANCE | <input type="checkbox"/> CHANGE OF DOCTOR | <input type="checkbox"/> DISABILITY DETERMINATION |
| <input type="checkbox"/> LEGAL INVESTIGATION | <input type="checkbox"/> PERSONAL | <input type="checkbox"/> CONTINUING CARE | <input type="checkbox"/> WORKERS COMP |
| <input type="checkbox"/> OTHER (SPECIFY) _____ | | | |

Please provide current telephone number in the event we need to contact you: _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

Signature of individual or guardian or Personal Representative of patient's estate:

Date

NOTE: There will be a charge for a personal copy of your records. VA state rates apply. Pages 1-50 are \$.50 per page. Pages 51+ are \$.25 per page. Requested copies of digital films will be copied to a DCM format CD. Copies of up to 2 films will be made for a flat \$25.00 charge. For requests of 3 or more films, the charge is \$10.00 per film..