



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name _____ **Birthdate** _____

Medical Information to be Sent From:	Physician / person / company to receive records
Current Physician _____	Name _____
Address _____	Address _____
City _____	City _____
State _____ Zip _____	State _____ Zip _____
Phone () _____ Fax () _____	Phone () _____ Fax () _____

_____ Entire Medical Record, *INCLUDING* information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of sexually transmitted diseases and HIV / AIDS.

_____ Entire Medical Record, *EXCLUDING* information related to the treatment for:
 Substance abuse or dependency
 Psychiatric or mental health treatment
 Information related to testing or treatment of sexually transmitted diseases and HIV / AIDS.

_____ Record of care from _____ to _____ *INCLUDING* information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of sexually transmitted diseases and HIV / AIDS.

_____ Record of care from _____ to _____ *EXCLUDING* information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of sexually transmitted diseases and HIV / AIDS.

I RECOGNIZE THAT UNDER the Health Insurance Portability and Accountability Act of 1966 (HIPAA), I may limit the scope of the information that I authorize be disclosed. It is my expressed wish that all medical records of whatever kind, as described above, be released, subject only to any limitations. If you have any limitations please list them here _____

_____ If deemed necessary by Doctor _____, I authorize this information to be sent via FAX transmission. HIV, AIDS, and Mental Health records may not be FAXED unless it is an emergency.

This applies to all information in my medical record protected under the regulations in 42 Code of Federal Regulations, Part 2.

I authorize medical information to be released as indicated above. I understand this release is effective for a period of one year unless otherwise stated _____. I may revoke my consent at any time by providing written consent to the above named party.

I FURTHER UNDERSTAND that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and thereafter no longer subject to protection under HIPAA.

Signature of Patient or Patient's Legal Guardian **Date**

Witness **Date**

If Motor Vehicle Accident please provide the following information:		
Agent Name:		
Claim number:	COB:	Date of Accident:

If Worker's Compensation please complete the following:	
Employer:	
Employer Address:	
Supervisor Name:	Phone: ()
Date of Injury:	
Was it reported: yes no If yes, to whom:	
Claim #:	Adjuster's Name: