

Authorization to Release Health Information

Patient Name: _____ Chart #: _____

Date of Birth: _____ SSN: _____

Home Phone #: _____ Work Phone #: _____

I request and authorize:

Name: _____

Address: _____

City, State & Zip: _____

To release health information of the patient named above to:

Name: _____

Address: _____

City, State & Zip: _____

_____ Progress Notes _____ Immunization Records _____ Lab

_____ X-Ray _____ EKG _____ Entire Medical Record

_____ Other (specify): _____

I understand my express consent is required to release any health information related to testing, diagnosis, and/or drug and/or alcohol use. **Initial:** _____

If I have been tested, diagnosed, or treated for HIV (AIDS virus), sexually transmitted disease, pregnancy, psychiatric disorder/mental health, or drug and/or alcohol use, you are specifically authorized to release all health information relating to such diagnosis, testing, or treatment. **Initial:** _____

The purpose for releasing this information:

_____ Further Medical Care _____ 3rd Party Reimbursement

_____ Other (specify): _____

Signature of Patient or Legal Representative: _____

Relationship to Patient: _____ Date: _____

Witness: _____ Date: _____

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