



REQUEST FOR RELEASE OF MEDICAL INFORMATION FROM THE MEDICAL RECORD

PATIENT INFORMATION:

In accordance with the HIPAA Final Omnibus Rule, this authorization is for the release of your medical information within 30 days as required by law.

PATIENT'S NAME: _____
Last First M.I.

ADDRESS: _____

BIRTHDATE: ____/____/____ **CELL PHONE#:** _____ (alternative if no cell)
Month Day Year

EMAIL ADDRESS: _____

AUTHORIZATION:

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on my signing this authorization except as provided by law.

RELEASE FROM LIABILITY:

Provider / Organization Releasing Records: _____

I further understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information could potentially be re-disclosed and may no longer be protected by federal privacy regulations. Therefore, I release named entity above from any and all legal liability that may arise from the release of this information to the party named below.

ORGANIZATION RECEIVING INFORMATION:

Name: _____

Address: _____

INFORMATION TO BE DISCLOSED:

Date(s): _____ to _____

- | | |
|--|--|
| <input type="checkbox"/> All Medical Records | <input type="checkbox"/> Other (please specify): _____ |
| <input type="checkbox"/> History & Physical | _____ |
| <input type="checkbox"/> Imaging Results (MRI, CT, etc.) | _____ |
| <input type="checkbox"/> Lab Results | _____ |
| <input type="checkbox"/> Billing Records | _____ |

PURPOSE OF DISCLOSURE:

_____ – This request is made by patient or patient’s authorized representative
I understand that this authorization will expire one (1) year from the date of signature below.

SPECIAL AUTHORIZATION TO DISCLOSE SUPER-CONFIDENTIAL INFORMATION:

ALCOHOL/DRUG/INFECTIOUS DISEASE/MENTAL HEALTH RECORDS are protected by Federal Regulation 42 CFR, Part 2. Release of such records requires specific consent. I hereby grant such specific consent as initialed below. **I UNDERSTAND** that the following records are protected under federal and state law and cannot be disclosed without my written consent unless otherwise provided by law. **IN ADDITION TO ANY RECORDS CHECKED ABOVE, THE FOLLOWING INITIALED RECORDS MAY BE RELEASED:**

_____ HIV/AIDS related information and/or records _____ Mental Health information and/or records
_____ Sexually transmitted diseases _____ Drug/alcohol diagnosis, treatment or referral information

SIGNATURE: _____ **DATE:** _____
Patient or legal representative

RIGHT TO REVOKE AUTHORIZATION:

I MAY REVOKE THIS AUTHORIZATION AT ANY TIME, IN WRITING TO THE PRACTICE, BEFORE THE INFORMATION HAS BEEN RELEASED. I FURTHER UNDERSTAND THAT I HAVE A RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION UPON REQUEST.

SIGNATURE:

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Date: _____

Patient/Legal Representative Signature: *X* _____

Printed Name: _____

FOR OFFICE USE ONLY

Name of Person Preparing Copies

Date Copied

Method of Delivery of Records
(mail, fax, email, hand delivered)

Date Delivered