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Authorization for Release of Confidential Information

Patient Name: ______________________ **DOB:** ____________ **Phone #:** ______________

Patient's Address (Current Address on File):

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Patient's New Address (if different from current):

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I authorize PCP to: ☐ **Release my medical records to:** **OR** ☐ **Obtain my medical records from:**

Name: ______________________ Phone #: ______________________

Address: ____

Check confidential information to be released or obtained:

☐ Immunization record ☐ Problem list ☐ Most recent history and physical ☐ Entire record

☐ Laboratory results from: ______________ ☐ X-ray and imagine report from: ______________

☐ Progress notes from: ____

The purpose of this information is for: ☐ Transfer ☐ Continuity of Care ☐ Insurance

☐ Other: ______________________

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoke, this authorization will expire in 365 days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization.

Note: I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. I understand that this information is protected by law under certain conditions. By signing this statement, I am authorizing the release of this information to the requesting party above.

______________________ ______________________
Signature of patient or legal representative Date

______________________ ______________________
Relationship to patient, if not signed by patient Witness signature

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PLEASE DO NOT FAX ANY RECORDS MORE THAN 25 PAGES
PLEASE MAIL THEM TO ADDRESS ABOVE

REVISED 09/2020