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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient's Name: _____Date of Birth: _____

Address: _____

Medical Records. I hereby authorize_____
(Medical Doctor) to use or disclose the following: (check one)

☐ - **ALL Medical Records**. I request the release of my complete health record, which may or may not include protected health information (PHI) and electronic protected health information (ePHI) protected under HIPAA.

Restrictions - Medical information relating to diagnosis and treatment of alcohol or drug abuse, mental illness, STDs, or HIV/AIDS shall: (check one)

☐ - Be Included.

☐ - NOT Be Included.

☐ - **Specific Medical Records**: _____

Recipient. My medical records shall be disclosed to the following individual or entity:

Name: _____Contact: _____

Address: _____: Phone #_____

E-Mail: _____Fax: _____

Purpose of Release: Medical treatment

I understand that signing this authorization is voluntary and that my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon whether I sign this authorization.

I understand that I have the right to revoke this authorization at any time by writing to the Releasor, except where uses or disclosures have already been made based upon my original permission.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

_____ _____
Patient or Personal Representative Signature Date

_____
Printed Name

_____
Personal Representative Relationship to Patient