



Medical Release of Information Form

Patient Name: _____ Date of Birth: _____

Social Security #: _____ Previous Name: _____

I request and authorize _____
(Name of Physician and Clinic/Practice)

To release the medical record of the above named patient to:

Name of recipient: _____

Address: _____

City & State: _____ Zip Code: _____

Reason for release: _____

This request and authorization applies to: (initial appropriate line)

____ Health Care information relating to the following treatment condition or dates of treatment:

____ This information may contain x-ray reports, laboratory reports, EKG reports, other diagnostic reports, consults, etc.

____ All Health Care information **including** information relating to HIV/AIDS testing, sexually transmitted diseases, psychiatric disorders / mental health or drug and/or alcohol use. (Please circle all that apply)

____ All Health Care Information **excluding** information relating to HIV/Aids testing, sexually transmitted diseases, psychiatric disorders / mental health or drug and/or alcohol use. (Please circle all that apply)

____ I understand I have the right to revoke this authorization by providing a written request to do so to the above named physician or organization. I understand that the revocation will not apply to information that has already been released.

Signature of patient or authorized representative

Date

Relationship or status if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)

Unless otherwise revoked this Authorization will expire six months from the date signed. I understand that authorizing the disclosure of this health information is voluntary. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by confidentiality rules. If I have questions about disclosure of my health information I can contact *Cherrie Crawley at 972-739-3070.*