



### Request for Release of Medical Information

Make sure all information is complete to prevent a delay in release of information. (PLEASE PRINT)

Patient's Full Name: \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Previous Name: \_\_\_\_\_

This will authorize:

To Release to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### Medical information Requested:

- Complete Records
- Lab
- X-Ray Reports
- Pathology Reports
- Progress Notes
- Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### Reason for Release:

- To update my regular doctor (provider)
- I have been referred to another doctor
- I want/need a second opinion
- I am changing doctor (provider)
  - Dissatisfaction with care
  - My insurance changed
  - I am moving (New Address)
- \_\_\_\_\_  
\_\_\_\_\_
- Other: \_\_\_\_\_  
\_\_\_\_\_

#### SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I specifically authorize the release of data and information relating to (Note, you must mark yes or no):

Yes No

- 1. Substance Abuse (alcohol/drug abuse)
- 2. Mental Health/Depression (includes psychological testing)
- 3. HIV-Related Information (AIDS related testing)

This authorization will automatically expire one year from date of signature or until \_\_\_\_\_, 200\_\_. This consent may be revoked at any time by notifying the above named provider of information. Any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Disclosed information may be reviewed by contacting the provider of information.

#### RESTRICTIONS:

This authorization is being given with the understanding that the receiver may not further use or disclose the medical information unless another authorization is obtained from me or unless such use of disclosure is specifically required or permitted by law.

Signature of patient or legal Guardian (Patients over 18 must sign own release) \_\_\_\_\_ Date \_\_\_\_\_

Relationship, if not the Patient \_\_\_\_\_ Daytime Phone # \_\_\_\_\_ Witness \_\_\_\_\_

#### ***There is a Service Fee for Medical Record Transfer Requests***

Reviewed and approved by  
Dr. \_\_\_\_\_

For Clinic Use Only

Patient Pick up Date Needed \_\_\_\_\_