AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

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NAME OF PATIENT (print) _____ DATE OF REQUEST ___/___/____

PATIENT MAY ALSO BE KNOWN AS: _____

DATE OF BIRTH ___/___/____ SOCIAL SECURITY (LAST 4 ONLY) XXX-XX-_____

RELEASE INFORMATION FROM:	**RELEASE INFORMATION TO:**
Name: _____ Address: _____ _____ _____ Phone: (____) _____ Fax: (____) _____ **DO NOT FAX IF OVER 20 PAGES**	Name: _____ Address: _____ _____ _____ Phone: (____) _____ Fax: (____) _____ **DO NOT FAX IF OVER 20 PAGES**

PURPOSE OF RELEASE: ___Treatment/Continued Care ___Legal Purposes ___Personal
___Other (explain) _____

INFORMATION TO BE RELEASED (Required)

_____All Routine Records (Notes, History & Physical, Labs, Radiology, Diagnostic Testing)

_____Other: (explain) _____

_____Specific Service Dates From: _____ To _____

* I understand the information to be released may include records related to behavior and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS, and genetics.
* This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it.
* Revocation must be made in writing to the provider/facility releasing the information.
* The provider/facility will not condition treatment on whether I sign the authorization.
* **I may be charged for copies in accordance with state law.**
* Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal law.
* The authorization will expire one year from the date of signing unless I indicate an earlier date or event here: _____.

_____ _____
Patient or Guardian Signature Date Signed

_____
Printed Name of Person Signing