

MEDICAL RECORDS AUTHORIZATION

Patient's Name:	Date of Birth:
Address:	City, ST, Zip:
Phone:	Email:

PLEASE RELEASE THE INFORMATION BY THIS METHOD: (Select 1 option only)

Secure Email / 1 – 2-days (provide Email here):

Fax / 2 – 3 days (provide Fax number here):

Mail / Allow 5 – 7 days

RELEASE THE INFORMATION FROM:

Physician/Practice: _____

Address: _____

City, ST: _____

Phone: _____

RELEASE THE INFORMATION TO:

Physician/Practice: _____

Address: _____

City, ST: _____

Phone: _____

PROVIDE DATES OF SERVICE

Provide Records from(m/d/y) _____ through _____

Records for all dates of service

PURPOSE FOR RELEASE

Continuing Care

Transfer of Care

Disability

Legal/Attorney

Insurance

Other:

RECORDS TO BE RELEASED (45 CFR § 164.508(c))

Office Notes

Lab Reports

Operative Reports

X-Ray Reports

CD of Images done at PCI

Additional Information:

Please indicate your acceptance by checking the following boxes:

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization (45 CFR § 164.508(c)(2)(i)).

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes (45 CFR § 164.508(c)(2)(ii)).

I understand that my records are confidential and cannot be disclosed without my written authorization except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) (45 CFR § 164.508(c)(2)(iii)).

This authorization will expire 180 days from the date of my signature unless I revoke the authorization prior to that time.

Signature: _____ **Date:** _____

Reason if patient is unable to sign: _____
(Provide guardianship, executor of estate, death certificate, or power of attorney paperwork with request)