Patient Identifier Label or FIN Number

Medical Records — Release of Information

MR #: _____

❒ Mail records ❒ Fax records ❒ ID verified ❒ Logged

Employee Name: _____ Date Completed: _____

AUTHORIZATION TO OBTAIN AND DISCLOSE MEDICAL INFORMATION

Patient name: _____ Date of Birth: _____

Address: _____ City/ State/ Zip: _____

Tel: _____ Fax: _____

Release records to:

❒ **Patient—Same information listed above** (please check box)

❒ **Other**—If you are releasing **YOUR** records to **ANOTHER**, please fill in **THEIR** information below (individual or healthcare facility)

Name: _____

Address: _____ City/ State/ Zip: _____

Tel: _____ Fax: _____

Information you want to obtain/disclose: Please provide as much information as possible (i.e. type of service, month, year, etc.)

_____

_____

_____

Obtaining your specially protected records: If my information contains any of the types of records listed below, additional laws relating to the use and disclosure of my information may apply. By placing my initials in the applicable spaces, I understand and agree that this information will be disclosed to the personnel listed above.

_____ Mental Health records _____ Genetic testing information

_____ HIV/ AIDS testing _____ Drug/ alcohol diagnosis, treatment or referral information

Purpose of this request (check one):

❒ Continuing care ❒ Personal records ❒ Legal ❒ Insurance ❒ Other: _____

Restrictions: I understand that the information released may be subject to re-disclosure by the recipient and may no longer be protected.

Rights: I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I may inspect or copy any information to be used and/ or disclosed under this authorization in accordance with organizational policy. I understand that I have the right to revoke this authorization in writing. My revocation will be effective upon receipt, but will not be effective to the extent that this organization has taken action in reliance upon this authorization.

_____

Patient/ Legal guardian signature **Date** **Guarantor, POA, or other legal representative**

Note: This authorization will expire 12 months from date of signing unless revoked or otherwise specified below:

(Enter alternative expiration date or event): _____