844-746-8537

844-542-6363

844-786-2355

844-463-7669

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ **Date of Birth:** _____

Address: _____ **SS #:** _____

Phone: _____ **Email:** _____

I request and authorize the release of healthcare information of the patient named above to:
Name:
Address:

Phone:
Fax:

The request and authorization applies to healthcare information relating to the following treatment, condition or date:

- ❑ Entire record
- ❑ Lab reports
- ❑ Operative reports
- ❑ Factsheet/Demographics
- ❑ History and Physical
- ❑ Physician Notes
- ❑ Physical Therapy
- ❑ Radiology Reports
- ❑ Other

I, the undersigned, authorize _____ (Disclosing Institution) and its employees to release information from my medical records as described above. I understand and acknowledge that the medical record may contain information regarding psychiatric disorders, Human Immune Virus (HIV) test results, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related conditions, alcohol and/or drug dependence/abuse. I also understand that information used or disclosed according to this authorization may be subject to redisclosure by the recipient and may no longer be protected. My failure to sign this authorization may result in my information not being released.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in one year.

I understand that treatment, payment, enrollment or eligibility for benefits will not be conditioned on my failure to sign this authorization.

I understand there may be charges for the copying and release of information and accept financial responsibility.

Patient Signature: _____ Date: _____