



AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Records Pertaining to:

Date of Birth: _____

Phone: _____

Email: _____

NAME OF PATIENT _____

Address: _____

Specific information to be released:

Other _____

Verbal/Telephone/e-mail contact

Summary of Treatment _____

Office Notes _____

Reports from labs or other outside studies _____

AND/OR

I hereby authorize the (SITE NAME AND ADDRESS) _____

to release the above information to the following person(s) and/or organization(s):

I understand that this information is not to be re-released to any person or facility except as provided by law. This release will continue until termination of treatment unless otherwise specified: _____. I understand that I may revoke this release of information at any time. I understand, however, that any release which was made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of my right to confidentiality. Unless I revoke this authorization prior to such time, this authorization to release information shall expire when the desired information is sent.

Special Authorization: My evaluation, diagnosis, and/or treatment relating to the conditions listed below may be released to the requestor identified above for the type of records indicated by my initials below:

___ Behavioral/Mental Health ___ HIV/AIDS ___ Alcohol/drug abuse/dependence

X _____
Signature of Patient (if 18 or older);
Or Parent (if patient under 18);
Or Legal Guardian; or Health Care Agent

Signature of Witness

X _____
Printed Name of Patient
or Authorized Person

X ____/____/____
Date

Printed Name of Witness

____/____/____
Date

X ____/____/____
Patient's Date of Birth

Title of Authorized Person (if applicable)