# AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization*.

AUTHORIZATION

I the undersigned hereby authorize ___________________________________________
(Physician/Healthcare Facility)
To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records by means of mail, fax or other electronic methods.

To: ___________________________________________
(Name)

___________________________________________
(Address)

______________________ ________ ___________
(City) (State) (Zip)

The medical information/records will be used to provide me with health care goods and services.

This authorization is:
[ ] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV diagnosis/treatment)
[ ] Limited to the following medical information:
________________________________________________________________________

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse _____ (initial) Tests for Antibodies to HIV ____ (initial)
Psychiatric/Mental Health _____ (initial) HIV Diagnosis/Treatment ____ (initial)

DURATION: This authorization shall become effective immediately and shall remain in effect for one (1) year from the date of my signature.

RESTRICTIONS: Permission for further use or disclose of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy or facsimile of this authorization shall me considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

______________________________ ______________________
[Signature of Patient or Legal Guardian] [Date]

______________________________ ______________________
[Print Name & Relationship if Other than Patient] [Date]

______________________________ ____________________________
[Patient's Date of Birth] [Patient's Social Security Number]

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