MEDICAL RECORD RELEASE AUTHORIZATION

PLEASE PRINT CLEARLY

PATIENT NAME: _____

ADDRESS: _____

PHONE #:_____BIRTHDATE: _____

1. I AUTHORIZE THE USE OR DISCLOSURE OF THE ABOVE NAMED INDIVIDUAL'S HEALTH INFORMATION AS DESCRIBED BELOW:
2. The following individual or organization is authorized to make the disclosure:
   Facility/Dr. Office Name: _____
   Address: _____
   Phone #: _____
3. For the purpose of review/examination and further authorize you to provide such copies of the records as may be requested. The foregoing is subject to such limitation as indicated below:
   _____ Entire Record _____ Substance Abuse
   _____ Psychiatric/Mental Health Information _____ HIV Information
   Specific Information: _____
4. This information may be disclosed to and used by the following individual or organization:
   Facility/Dr. Office Name: _____
   Address: _____
   Phone #: _____
   Reason for request: _____
5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke the authorization I must do so in writing and present my written revocation to the clinic. I understand that the revocation will not apply to information that has already been released in response to this authorization.
6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

   This authorization will automatically expire six (6) months from the date signed, unless otherwise indicated or revoked. I understand that I may revoke this consent at any time except to the extent that action has been taken in reasonable reliance upon the document.

_____

Signature of Patient or Legal Representative Date

_____

Signature of Witness Date