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AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF MEDICAL INFORMATION

Treatment, payment, enrollment of eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.

REQUESTING medical information **FROM**:

_____
Name of Health Care Provider

_____
Name of Medical Office/Hospital

_____
Street Address

_____
City, State, and Zip Code

_____
Phone Number

_____
Fax Number

Please **SEND** medical information **TO**:

_____
Name of Health Care Provider

_____
Name of Medical Office/Hospital

_____
Street Address

_____
City, State, and Zip Code

_____
Phone Number

_____
Fax Number

I hereby request and authorize _____ to release and/or disclose the medical information as indicated below to the healthcare provider, entity, or person I have indicated above.

_____ _____/_____/_____
Name of the patient (list other names used) Date of Birth

_____ (_____)_____-_____
Address City State Zip Code Telephone Number

RECORDS TO BE RELEASED AND/OR DISCLOSED (PLEASE MARK ALL THAT APPLY)

_____General Medical Information (From_____to_____)
_____Diagnostic Imaging Reports (From_____to_____)
_____Laboratory Results (From_____to_____)
_____Mental Health (From_____to_____)
_____Alcohol/Drug (From_____to_____)
_____HIV/STD Test Results (From_____to_____)
_____Information regarding other Specific Injury or Treatment (Please Specify):_____
_____ (From_____to_____)

I request that health information released and/or disclosed pursuant to this authorization be used for the following purpose only:

_____

I hereby authorize disclosure of health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____ _____
Signature of Patient or Patient Representative Relationship (if not patient) Date