

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

Patient Name (Print): _____ Record Number: _____

Date of Birth: _____ AKA (other names): _____

I am the ___ PATIENT ___ GUARDIAN ___ CONSERVATOR ___ DESIGNEE and hereby authorize

_____, located at _____

_____ to disclose medical information for the above-named.

Send to: (Name of person, organization, or agency and address)

_____ Purpose of Disclosure: _____

Dates of Service to Release: _____

Restrictions: I understand that the recipient of this information may not use or disclose this information except for the express purpose identified above, unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Notice: Unless specified below, this authorization is for full disclosure of all records, including clinical findings, diagnosis, treatment, assessment, recommendations for further care, names of all health care personnel, dates of hospitalizations and ambulatory visits, charges, and any information that may be related to drug, alcohol, psychiatric conditions, and/or sexually transmitted disease, including AIDS information.

Exclusions (please initial): Drug/Alcohol_____, Mental Health/Psychiatric_____, Sexually Transmitted Disease_____ HIV/AIDS _____

This authorization is valid for one year or until _____, whichever comes first.

Patient Signature: _____ Date: _____

Print Name here: _____

Signature of Parent/Guardian/Conservator/Designee (if applicable): _____

Relationship: _____ Date: _____

A photocopy of this release is as valid as the original.

I understand that this consent is only for the specific purpose stated and may be revoked at any time. This consent expires automatically when its purpose has been accomplished.