

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Date: _____ Account #: _____

I authorize: _____ Address: _____
(Company Name)

To release information from the medical record of: _____
(Patient's Full Name)

Reason for Request: _____

TO: _____

ATTN: _____

For the purpose of review / examination, I authorize you to provide the following information:

COMPLETE COPY OF MEDICAL RECORD

DISCLOSURE LOG

SPECIFIC INFORMATION

I give specific permission to release any information related to:

___ SUBSTANCE ABUSE ___ PSYCHIATRIC / MENTAL HEALTH INFORMATION ___ HIV / AIDS INFORMATION

This authorization will expire sixty (60) days from the date signed. I understand that I may revoke this authorization, in writing, at any time except to the extent that action has been taken in reliance thereon. I understand that if I am releasing this information to an entity or individual not covered by HIPAA, this information is no longer protected by HIPAA.

Patient or Legal Guardian's Signature: _____

Relationship to Patient: _____

Witness: _____ Practice: _____

Identifying Information:

Name at time of treatment, if other than above: _____

Date of Treatment: _____

Date of Birth: _____ SS#: _____