# AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

***This authorization must be written, dated and signed by the patient or by a person authorized by law to give this authorization.***

I authorize _____ to release a copy of the medical information
(Name of Hospital/Health Care Provider)
for _____ to _____
(Name Of Patient) (Name and Address of Recipient)
_____

The information will be used on my behalf for the following purpose(s): _____
_____
Please send information including the diagnosis and records of any treatment or examination rendered to me during the period from _____ to _____

By initialing the spaces below, I specifically authorize the release of the following medical records, if such records exist:

_____ Please send the entire medical record (all information) to the above name recipient. The recipient understands this record may by voluminous and agrees to pall all reasonable charges associated with providing this record.

_____ Most recent history – last ___ yrs. / mo.
_____ Clinician office chart notes
_____ Billing statements
_____ Pathology reports
_____ Other _____
_____ Hospital records
_____ Diagnostic imaging reports
_____ Laboratory reports
_____ Correspondence (permission for communication between provider and recipient)

_____ HIV/AIDS related records (Must be initialed to be included in other documents.)
_____ Mental health information (Must be initialed to be included in other documents)

_____ This authorization is limited to the following treatment:
_____
_____ This authorization is limited to the following time period:
_____
_____ This authorization is limited to a workers' compensation claim for injuries of
_____ (Date)

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

_____ _____
(Date) (Signature of patient or person authorized by law)

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