AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

By signing this form, I authorize the following information to be released from the medical record of:

Patient Name: _____ **DOB:**_____ **SS#:**_____

Street: _____ **City**: _____ **State:**_____ **Zip:**_____

To: _____ **From:** _____

_____ _____

_____ _____

Phone #:_____ Fax #:_____ Phone #:_____ Fax #:_____

PLEASE CHECK INFORMATION TO BE RELEASED

Records requested for medical treatment beginning on _____ to _____.

☐ Clinic Visit Notes ☐ X-ray Report ☐ Billing Statement

☐ Copies of Outside Records ☐ Lab Report ☐ All Records

☐ Other (specify):_____

Include information (if applicable):

☐ HIV/AIDS ☐ Alcohol or drug ☐ Hepatitis B ☐ Mental Health

This information is to be used for the specific purpose designated below:

☐ Continued Patient Care ☐ Personal Use ☐ Disability Determination

☐ Insurance Company ☐ Attorney/Legal ☐ Review Medical Record Only

☐ Second opinion by another physician, Dr. _____

☐ Other (specify): _____

I understand that my records are confidential and cannot be disclosed without my written authorization, except as otherwise provided by law.

I understand that a photocopy of this authorization is as valid as the original.

I may be charged for copies depending on the number of pages requested.

I understand that I may revoke this authorization at any time. In the absence of my prior revocation, this authorization will automatically expire in one year.

_____ _____

Signature of Patient or Legal Representative Date

Witness: _____

Please fax to (512) 320-1588 Attention: Medical Records