**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

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| **PATIENT INFORMATION** |
| Name of Patient | Date of BIrth |
| Home Address | City | State | Zip |
| Cell Phone | Home Phone |

**RECORDS MAY BE RELEASED FROM:**

I authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Healthcare Facility/Physician Phone

to release information contained in my medical record (including if applicable, information about HIV infection or AIDS, information about substance abuse treatment and information about mental health services).

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| **RECORDS MAY BE RELEASED TO:** |
| Healthcare Facility/Physician/Other |
| Address | City | State | Zip |
| Phone | Fax |

 **INFORMATION TO BE DISCLOSED:**❒ All Records ❒ History and Physical ❒ Progress Notes ❒ Labs

❒ X-Ray Reports ❒ Consult ❒ Discharge Summary ❒ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specific Dates of Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PURPOSE AND NEED FOR DISCLOSURE:**
❒ Attorney/Legal ❒ Insurance Continued ❒ Patient Care ❒ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(For health records pertaining to HIV infection or AIDS, the patient/patient representative must describe how the information to be disclosed is relevant to the purpose and need for such disclosure).

I understand that I have the right to revoke this authorization at any time. I understand that if l revoke this authorization, I must do so in writing and present my written revocation to the Privacy Officer, Twelve Oaks Pediatrics. We may have already released the information based on your original authorization. We will not release any additional information after we received your revocation. We will not condition treatment or payment based on this authorization or revocation of this authorization unless otherwise allowed by law. Your protected health information will be disclosed as specified in this authorization. This authorization will expire 120 days from the date of this signature, or when we have completed the disclosure(s) you have requested, whichever is shorter. This information could be subject to re-disclosure by the recipient and may no longer be protected.

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Parent/Guardian/Patient Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name

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Relationship to Patient

**Federal and State Laws permit a fee to be charged for the copying of patient records.**