



**AUTHORIZATION TO RELEASE  
MEDICAL INFORMATION**

PATIENT INFORMATION

Patient Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

INFORMATION TO BE RELEASED FROM

Name of Physician/Organization	Street Address	City / State / Zip
_____	_____	_____
_____	_____	_____

INFORMATION TO BE RELEASED TO

Name of Physician/Organization	Street Address	City / State / Zip
_____	_____	_____
_____	_____	_____

PURPOSE OR NEED FOR THIS INFORMATION (Please check a box)

- Moving    Specialist Appt.    Dissatisfaction    Change of Insurance Plans  
 Other (specify) \_\_\_\_\_

TYPE OF INFORMATION TO BE RELEASED (No information will be released unless a box is checked)

**General Release**

- |  |  |
|--|--|
| <input type="checkbox"/> Medical Records/Excluding Protected Records<br>(this will be limited to 1 year of information including Lab, x-ray reports unless otherwise stated) | <b>DATES OF TREATMENT</b><br>From _____ To _____ |
| <input type="checkbox"/> Other Records (specify)   | From _____ To _____                              |

**Information Protected by State/Federal Law**

- |  |                     |
|--|---------------------|
| <input type="checkbox"/> Drug Abuse Diagnosis/Treatment  | From _____ To _____ |
| <input type="checkbox"/> Alcoholism Diagnosis/Treatment  | From _____ To _____ |
| <input type="checkbox"/> Mental Health Diagnosis/Treatment<br>(may include treatment of pain management and center women's health or psychiatry) | From _____ To _____ |
| <input type="checkbox"/> Sexually Transmitted Disease Diagnosis/Treatment or Counseling<br>(includes AIDS/HIV)                                   | From _____ To _____ |
| <input type="checkbox"/> Communicable Disease and Related Information  | From _____ To _____ |
| <input type="checkbox"/> Genetic Testing Information   | From _____ To _____ |

**THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE AFTER ONE YEAR** (or 60 days for drug and alcohol abuse records) from the date of signing. The undersigned may revoke this authorization at any time by providing written notice of revocation.

With respect to drug and alcohol abuse treatment, information or records regarding communicable disease-related information, the recipient of this information understand that it is prohibited from making any disclosure of this information unless further disclose is expressly permitted by written consent of the undersigned or otherwise permitted by applicable law.

\_\_\_\_\_  
**Signature of Patient OR Legal Representative**

\_\_\_\_\_  
**Please Print Name of signing party**

\_\_\_\_\_  
**Date Signed**

**There may be a charge for  
providing copies of medical records.**

**NOTE:** If this request is made by mail, this office requires the request be notarized by a State Notary Public.