Print Form

CONSENT FOR RELEASE OF MEDICAL INFORMATION

Patient name:_____ Date of Birth_____

Address:_____

Phone Number:_____ Treatment dates from:_____ to_____

I authorize: (enter your current physician's information)

_____

_____

_____

To release copies of my medical records to: (enter your new physician)

_____

_____

_____

I authorize release of information of the following portions of my medical record:

_____ Mental Health _____ HIV/AIDS
_____ Substance Abuse _____ Communicable Disease
_____ All _____ Only the following:_____

I understand that this information shall be in effect for 180 days following the date of signature. However, I understand that this authorization may be revoked at any time by giving oral or written notice to the medical office. A photocopy of this authorization shall constitute a valid authorization. I understand that once my medical records have been released, the medical office cannot retrieve them and has no control over the use of the already released copies.

I hereby release _____ from any and all liability which may arise as a result of my authorized release of records.

Should my case require review by a governing agency or another medical profession actively involved in my care to make a final determination, it is with my consent that a copy of these records will be submitted to the agency or medical profession for this review.

Patient (or legal representative)_____ Date:_____

Relationship to Patient:_____ Witness:_____

NOTICE: The information has been disclosed to you from records whose confidentiality has been protected by federal and state law. You are prohibited from making further disclosures of such information without specific consent of thezzerson to whom such information pertains or as otherwise permitted by state law. A general authorization is not sufficient for this purpose.