GENERAL MEDICAL RECORDS RELEASE AND AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please complete the following information:

Patient Name: _____ Date of Birth: ___/___/___

Address: _____
Street Apt. / Unit City State Zip

Phone: (____)_____ Social Security #: _____

I authorize the custodian of records _____ to disclose/release the following
Person or Entity
information* (Mark all applicable with an X):

___ All records
___ Laboratory / pathology records
___ X-ray / radiology records
___ Billing records
___ Abstract / summary
___ Pharmacy / prescription records
___ Other (describe specifically): _____

**Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

These records are for services provided on the following date(s): _____

Please send the records listed above to (use additional sheets if necessary):

Name: _____
Address: _____
Street
_____
City State Zip
Phone: _____
Fax: _____

Name: _____
Address: _____
Street
_____
City State Zip
Phone: _____
Fax: _____

The information may be used/disclosed for each of the following purposes:

___ At my request (only the patient can check this box)
___ For my health care
___ For payment / insurance
___ For employments purposes
___ Other: _____

This authorization shall expire no later than ___/___/___ or upon the following event _____ (whichever is sooner), and may not be valid for greater than one year from the date of signature for medical records. I understand that after records are disclosed my health information may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment: receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure or protected health information and that there are no claims or orders pending or in effect that would prohibit, limi, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____
Signature of patient (or patient's personal representative) Date

_____ _____
Printed name of patient representative Representative's authority to sign for patient
(*i.e. parent, guardian, power of attorney, executor)*