

## Authorization for Use and Disclosure of Medical Information

**Patient Information:** Print name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

SS# (Last 4 digits) \_\_\_\_\_ Maiden or prior last name: \_\_\_\_\_ Phone # \_\_\_\_\_

Please release my healthcare information from:

Please send my healthcare information to:

Name of Facility/Provider: \_\_\_\_\_

Name of designated recipient: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone/Fax Number: \_\_\_\_\_

Phone/Fax Number: \_\_\_\_\_

### **Information to be released**

**Format:** Paper  Electronic (CD)

- |  |  |
|--|--|
| <input type="checkbox"/> Abstract of Health Information  | <input type="checkbox"/> Records from _____ to _____ only    |
| <input type="checkbox"/> The most recent 2 years of pertinent information (chart notes, labs, ultrasounds and special tests) |  |
| <input type="checkbox"/> Complete Medical Record   |  |
| <input type="checkbox"/> Other (Specify): _____  | <input type="checkbox"/> Billing Records from _____ to _____ |

### **Purpose of Request:**

- |   |   |
|---|---|
| <input type="checkbox"/> Continuing Care        | <input type="checkbox"/> Workman's Comp.          |
| <input type="checkbox"/> Personal use           | <input type="checkbox"/> Disability Determination |
| <input type="checkbox"/> Other (Specify): _____ |   |

### **Fees for Copying Medical Records**

The following fees will apply:

The actual retrieval fee for medical records stored off-site \$ \_\_\_\_\_.

A base preparation fee of \$ \_\_\_\_\_ (**waived for patient requests**).

A charge of \$ \_\_\_\_\_ cents per photocopied page, and the actual cost of postage \$ \_\_\_\_\_.

These fees must be paid before your records can be released.

### **My Rights**

I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing, and present to the office where my information is being released. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or receive copies of the information to be used or disclosed, as provided in the Code of Federal Regulations (CFR 164.524). I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

### **Patient Authorization**

I understand that I may be charged the fees shown above for the copying of my medical records. I authorize Name of Practice to release my medical records (including medical information related to the diagnosis or treatment for HIV testing, drug and alcohol, or a psychiatric condition) as specified above.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient, Guardian\*, Authorized Representative\*)

\* Must provide documentation to prove authority to sign on behalf of the patient)

**THIS AUTHORIZATION WILL EXPIRE 90 DAYS FROM THE DATE SIGNED**