

### **Authorization to Release Medical Records**

I hereby request and authorize the use and/or disclosure of Medical Records:

- ALL medical records **except** sexually transmitted diseases (STD's) and psychological (mental health) records
- All medical records **including** sexually transmitted diseases (STD's), HIV, AIDS, **and** Psychological records
- Specific information: \_\_\_\_\_

Patient Full Legal Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Other Names Used: \_\_\_\_\_ SS Number: \_\_\_\_\_

### **Obtain Records From:**

Name: \_\_\_\_\_

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

(Street) (City) (State) (ZIP)

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

Reason for Request of Records: \_\_\_\_\_

### **Disclose Records To:**

Name: \_\_\_\_\_

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

(Street) (City) (State) (ZIP)

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

**Please allow up to 2 weeks to process your records request. This request expires 12 months from the date signed.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

*All information released to or obtained from this facility will be used for the purpose of evaluation of medical status of this patient. Information released to us will not be further transferred from this facility without additional patient authorization. Authorization for the release of this patient's records may be withdrawn at any time. Please note: All medical records will be copied for the patient for free of charge the first time, however, a fee will be assessed accordingly for any additional copies.*