Authorization for Medical Records to be Released

*Please Print
Physician or facility to provide records: _____
Address: _____ Phone: _____
_____ Fax: _____
Patient Name: _____ Date of Birth: _____
Address: _____ Phone: _____
_____ Social Security # : _____
Person to receive records: _____
Address: _____ Phone: _____
_____ Fax: _____

I authorize the health care provider to release information specified below to the organization, agency, or individual named on request. I specifically give permission to release the information regarding the following conditions:

_____ Substance / Drug Abuse if any
_____ AIDS / HIV if any
_____ Psychological or Psychiatric if any

Information to be disclosed: *Initials*

1. Only records generated by this facility (not including records received from other sources). _____
2. All medical records at their facility. _____
3. Only certain portion of records (please specify below) _____

_____
_____
_____

I understand in signing this release I give the permission to release my confidential information to the name above.

Signature: _____ Date: _____

- To further help us in storing your records, please check the appropriate box.
  - ☐ Please purge my records, as I am transferring care.
  - ☐ Please keep my records current, as I am still a patient in your care.