REQUEST FOR RELEASE OF MEDICAL INFORMATION FROM THE MEDICAL RECORD

PATIENT INFORMATION:

In accordance with the HIPAA Final Omnibus Rule, this authorization is for the release of your medical information within 30 days as required by law.

PATIENT'S NAME: _____
Last First M.I.

ADDRESS: _____

BIRTHDATE: _____/_____/_____ **CELL PHONE#:** _____(alternative if no cell)
Month Day Year

EMAIL ADDRESS: _____ _____

AUTHORIZATION:

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on my signing this authorization except as provided by law.

RELEASE FROM LIABILITY:

Provider / Organization Releasing Records: _____

I further understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information could potentially be re-disclosed and may no longer be protected by federal privacy regulations. Therefore, I release named entity above from any and all legal liability that may arise from the release of this information to the party named below.

ORGANIZATION RECEIVING INFORMATION:

Name:

Address:

INFORMATION TO BE DISCLOSED:

Date(s): _____ **to** _____

_____ **All Medical Records**
_____ **History & Physical**
_____ **Imaging Results (MRI, CT, etc.)**
_____ **Lab Results**
_____ **Billing Records**

_____ **Other (please specify):** _____
_____
_____
_____
_____

PURPOSE OF DISCLOSURE:

_____ – This request is made by patient or patient's authorized representative

I understand that this authorization will expire one (1) year from the date of signature below.

SPECIAL AUTHORIZATION TO DISCLOSE SUPER-CONFIDENTIAL INFORMATION:

ALCOHOL/DRUG/INFECTIOUS DISEASE/MENTAL HEALTH RECORDS are protected by Federal Regulation 42 CFR, Part 2. Release of such records requires specific consent. I hereby grant such specific consent as initialed below. **I UNDERSTAND** that the following records are protected under federal and state law and cannot be disclosed without my written consent unless otherwise provided by law. **IN ADDITION TO ANY RECORDS CHECKED ABOVE, THE FOLLOWING INITIALED RECORDS MAY BE RELEASED:**

_____ HIV/AIDS related information and/or records

_____ Sexually transmitted diseases

_____ Mental Health information and/or records

_____ Drug/alcohol diagnosis, treatment or referral information

SIGNATURE: _____ **DATE**: _____

Patient or legal representative

RIGHT TO REVOKE AUTHORIZATION:

I MAY REVOKE THIS AUTHORIZATION AT ANY TIME, IN WRITING TO THE PRACTICE, BEFORE THE INFORMATION HAS BEEN RELEASED. I FURTHER UNDERSTAND THAT I HAVE A RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION UPON REQUEST.

SIGNATURE:

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Date: _____

Patient/Legal Representative *Signature*: X _____

Printed Name: _____

_____ _____

Name of Person Preparing Copies **Date Copied**

_____ _____

Method of Delivery of Records **Date Delivered**

(mail, fax, email, hand delivered)