

Authorization to Release Medical Records

Patient: _____ Birth Date _____

Social Security No. (if applicable) _____

PHYSICIAN RELEASING RECORDS:

PERSON TO RECEIVE RECORDS:

Name _____

Name _____

Address _____

Address _____

City _____

City _____

Phone (____) _____

Phone (____) _____

DATE(S) OF SERVICE: _____

MEDICAL INFORMATION TO BE SENT:

_____ Entire Medical Record, **INCLUDING** information related to the treatment for substance abuse or dependency as protected under Title 42, CFR (if any); psychiatric or mental health treatment including progress notes reflecting communications made to a social worker, psychologist or psychiatrist; information related to testing or treatment of sexually transmitted diseases and HIV/AIDS.

_____ Entire Medical Record, **EXCLUDING** information related to the treatment for substance abuse or dependency as protected under Title 42, CFR (if any); psychiatric or mental health treatment including progress notes reflecting communications made to a social worker, psychologist or psychiatrist; information related to testing or treatment of sexually transmitted diseases and HIV/AIDS.

SELECTED PORTIONS OF THE MEDICAL RECORD ONLY:

- | | | |
|---|---|--|
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Billing Statements |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Other, please specify _____ |
| <input type="checkbox"/> Consults | <input type="checkbox"/> Discharge Summary | _____ |

I authorize medical information to be released as indicated above. I understand this release is effective until _____, but that I may revoke my consent at any time by providing written revocation to the above named physician.

Patient, Patient's Legal Guardian, or Personal Representative (**PRINT Name**)

Date

Patient, Patient's Legal Guardian, or Personal Representative (**Signature**)

Relationship to Patient (if applicable)

Witness (**Signature**)

Date

You can fax your completed MMR form to 440-875-8842.