

Authorization for Release of Medical Information



Please complete this form thoroughly. Your medical record cannot be released until this form is completed, signed by the patient or legal guardian and returned to our office. There may be a processing fee associated with this request.

Patient information

Patient first name: _____

Patient last name: _____

Date of birth: _____

Phone: _____

Address: _____ Apt #: _____

City: _____ State: _____

Zip: _____

Who has your records now?

Physician: _____

Address: _____

City: _____ State: _____

Zip: _____

To whom do you wish to release your records?

Physician: _____

Address: _____

City: _____ State: _____

Zip: _____

Which records would you like released?

- All records, **or**
- Dates of service from: _____ to: _____

You must specifically check yes or no for each category below:

- Abortion Yes No
- AIDS..... Yes No
- HIV Testing..... Yes No
- Alcohol Abuse Yes No
- Substance Abuse Yes No
- Illegitimate Birth Yes No
- Infertility Studies Yes No
- Mental Health Visits Yes No
- Anxiety/Depression..... Yes No
- Eating Disorders Yes No
- Sexual Assault/Rape..... Yes No
- Sexually Transmitted Disease.... Yes No

Signature

I hereby authorize the release of the above information to the address indicated.

Patient signature:

Date: _____

Parent/Guardian signature:

Date: _____

This authorization is valid for 90 days and may be revoked at any time in writing prior to the expiration date.

Please allow 10 business days for your records to be released.