AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

TO: _____

Patient Name: _____ **Date of Service:** _____

This is to authorize any physician; hospital; medical attendant; nurse; technician; psychiatrist; psychologist; counselor; or any other health care provider to furnish to: _____

_____,
(insert name(s) of persons/agencies authorized to receive information pursuant to this release)

the following specific medical records constituting protected health information ("PHI") as that term is defined by Health Insurance Privacy and Portability Act of 1996, and any regulations enacted pursuant thereto, including opinions, reports, x-rays, bills, summaries, photo static copies, abstracts, and any other records, information or documents I may request that you may have in your custody or under your control regarding the patient whose name appears above:

_____

_____

_____
(Please specify minimum PHI necessary to fulfill this request. Please be specific, and include dates of treatment.)

If psychiatric records or HIV/AIDS information is included in these records, please complete this section:

- This release □ includes / □ DOES NOT INCLUDE authorization to release psychiatric records.
- This release □ includes / □ DOES NOT INCLUDE authorization to release HIV/AIDS information.
- This release □ includes / □ DOES NOT INCLUDE authorization to release substance abuse information.

NOTE: If this section is left blank, authorization to release psychiatric records, HIV/AIDS records and substance abuse records will be presumed to be DENIED.

This privilege I have to maintain the confidentiality of this PHI is not waived for any other organizations, individual or insurance company. By affixing my signature below, I acknowledge that I waive all liability whatsoever for any person who cooperates with this request to release medical records. A photocopy of this release may be used in place of the original. This release expires six (6) months from the date below. I understand that I may receive treatment from any healthcare providers mentioned in this release without executing this release. Further, I understand that this release may be revoked in writing by me. However, any actions taken by any party in reliance upon this release, taken before the written revocation is received by that party won't be affected by the revocation.

Dated: _____ Print Name: _____

Signature: _____
If patient's personal representative, describe relationship to patient: _____

Sworn and Subscribed before me this _____day of _____, 200__.

_____
Notary Public, or other officer authorized to take and certify acknowledgments and administer oaths