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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient:_____ D.O.B. _____

Address: _____

Telephone: _____ E-mail :_____

I hereby authorize & request that my medical records be released FROM : (name, address, phone of doctor or hospital)

1) _____
2) _____
3) _____

I hereby authorize & request that my medical records be released TO: (name, address, phone of doctor or hospital)

_____

_____

Specify what medical information is to be sent or received:

1) Complete chart	**5) Ekg**	**9) Last colonoscopy**	**13) Last PAP**	**17) Surgeries**
2) Office notes	**6) Echo**	**10) Last eye exam**	**14) Last Dexa**	**18) Other _____**
3) Labs	**7) Stress**	**11) Pathology**	**15) Immunizations**	**_____**
4) Chest	**8) Sleep study**	**12) Last mammogram**	**16) Vaccines**	**_____**

EXPIRATION DATE : ____/____/_____ **Is this a transfer ? YES / NO** **End of Study or Research ____/____/_____**

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment of alcohol and drug abuse. I understand that this authorization is voluntary & I may revoke it at any time per HIPAA guidelines. I have had full opportunity to read this authorization & confirm that the contents are consistent with my directions to you for use / disclosure of PHI. I am entitled to a copy when signed.

Signature of patient or legal representative: _____ Date: _____
Relationship to individual: _____

Revised: Oct. 2018