Authorization For Release of Medical Information

_____	_____
Patient's Full Name	Patients Social Security Number
_____	_____
Address	Patient's Date of Birth
_____	_____
City, State, Zip Code	Patient's Telephone Number

At the request of the individual, I _____, do hereby authorize _____ to release:

_____

Information Release To:

_____

Name of Company/Agency/Facility/Person

_____

Address

_____

Phone Number Fax Number

_____

City, State, Zip Code

The specific information that should be disclosed is (include dates of service):

_____

_____

_____

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/ADIS, OR MENTAL HEALTH WILL BE DISCLOUSED.

YES, DISCLOSE THIS INFORMATION *_____
NO, DO NOT DISCLOSE THIS INFORMATION *_____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of person or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – Note that Signature is required in two places.*

_____ _____
Signature of Individual Date of Individual's Signature

_____
Date of Birth or Social Security Number

_____ _____
Signature of Guardian or Personal Representative of Patient's Estate Date of Guardian's/Representative's Signature

_____
Description of Authority to Act for the Individual

A copy of this completed, signed, and dated form must be given to the Individual or other signator.

FEES FOR COPIES: Federal and state law permits a fee to be charged for the copying of patient records. This facility may contract with a business associate to provide this service and they will invoice you directly. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice.

Official Use Only

_____ _____ _____
Received Processed By Log #

Electronic Record Delivery Request

Complete this form, along with a HIPAA Authorization, to receive your medical records as electronic PDF files rather than as printed copies.

Requester Name	First	Last	
Street Address	Street	Suite / Apt #	
	City	State	Zip
Email Address for record delivery:			
Medical Records Requested			
Patient Name	First	MI	Last
Date of Birth			
Date of Service	From	To	

Please provide me with the medical records described above. I understand and agree that:

- I must provide a valid email address, either my own or that of my designated recipient.
- My records will be provided as PDF files.
- I will receive an email containing instructions for accessing my records.
- If I do not retrieve my records within 30 days, they will be deleted.
- There may be a fee for collecting my records. If so, an invoice will be included with the records.

Signature _____ Date**:** _____