

Patient Identification/Label
MR# _____



Delivery Options:
 Pick up in MRD Date: _____
 Mail Date: _____

Authorization for Release of Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations. I have the right to receive a copy of this Authorization after I sign it.

Patient Name: _____ Date of Birth: _____

Patient Address: _____ Phone #: _____
Street (Apt. #, PO Box #-as applicable), City, State and Zip code

Persons/Organization receiving the information: _____

Dates of service/treatment: _____ to: _____ at _____
(Facility)

Description of information authorized to be released/disclosed:

- | | | |
|--|---|---|
| <input type="checkbox"/> All Reports below | <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> History & Physical exam | <input type="checkbox"/> Radiology/CD | <input type="checkbox"/> Emergency Room Reports |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Laboratory reports | <input type="checkbox"/> Discharge Instructions |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Progress Notes | |
- Other _____

Type of Media: Paper Electronic on CD (PDF format)

For the following reason(s): Legal Purposes Insurance Purposes Employer Requirement

Continuation of Care Other _____

Expiration: This Authorization will expire on _____ (MM/DD/YY) [cannot exceed one year from date below].
If expiration date is left blank, the authorization shall remain effective for 60 days after the date listed below.

I understand that my medical records (including any psychiatric, alcohol or drug abuse information) are protected by Federal Regulations and cannot be disclosed without written consent unless otherwise provided for in said regulations. I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released.

I understand that I may revoke this Authorization at any time by notifying the providing organization in writing but, if I do, it will not have any effect on any actions taken before receiving the revocation.

I have read the above and authorize the disclosure of such health information as described herein. I understand that treatment, payment, enrollment or eligibility for benefits is not conditioned upon the execution of this Authorization.

Signature of patient or patient's representative (Photo identification required) _____ Date _____

Printed name of patient's representative: _____
(Provide document to prove authority to act on behalf of patient)

Representative's address: _____

Relationship to the patient: _____

Signature of witness _____ Date _____