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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the named health care provider to release the information or records specified to upon request in person or by mail to the address specified at the time of the request.

Provider: (name and address)	Patient: SS#: DOB:

Request from:

Send to:

RECORDS AUTHORIZED TO BE RELEASED:

- ☐ Admission history and physical
- ☐ Discharge summary
- ☐ Complete hospital chart
- ☐ Office notes
- ☐ Outpatient records
- ☐ Lab reports
- ☐ Radiological images
- ☐ Consultation notes or reports
- ☐ Complaints or grievances filed, with responses or dispositions
- ☐ Psychiatric and other mental health records
- ☐ Records relating to drug or alcohol abuse (must specify the extent or nature of the records to be released)
- ☐ Medication administration logs, dietary logs, staff contact or service logs, and other records that may not be part of my individual medical record, but which contain information relating to me (These records should be redacted to protect information pertaining to other patients.)
- ☐ Other (specify):___

Extent or nature of records to be released: ___
(example, specific hospitalization or visit)

This information will be used for the purpose of :

- ☐ Investigating an allegation of abuse
- ☐ Providing advocacy services
- ☐ Other activities at the request of the individual
- ☐ Verifying my eligibility for services offered by the
- ☐ Legal representation

This authorization will expire one year from the date of the signature below. I understand that I can revoke this authorization at any time by writing to the health care provider or to the , but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

I also understand that:

- I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal.
- Federal privacy regulations will no longer apply to the information disclosed, and that may redisclose the information.
- I am entitled to receive a copy of this authorization.
- A copy of this authorization may be utilized with the same effectiveness as an original.

Patient or Representative Date

Name of Representative (print)

Relationship to Patient