

**AUTHORIZATION TO RELEASE HEALTH INFORMATION**

I authorize (Provider) \_\_\_\_\_ Provider Phone # \_\_\_\_\_

Medical Office: \_\_\_\_\_

Address: \_\_\_\_\_ Provider Fax # \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

**To release health/medical record information of:**

\_\_\_\_\_  
Patient's Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

This information is to be released to:

Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Address: \_\_\_\_\_ Fax # \_\_\_\_\_  
\_\_\_\_\_

**For the purpose of:** \_\_\_\_\_ **Permanent transfer to new provider**  
\_\_\_\_\_ **Consultation with:** \_\_\_\_\_  
\_\_\_\_\_ **Other** \_\_\_\_\_

I understand that the information I have agreed to release to the aforementioned party may include sensitive clinical information obtained during the dates listed below. These may or may not include treatment of substance or other abuse, HIV, psychiatric disorders, sexually transmitted diseases, etc., unless herein excepted: \_\_\_\_\_

**This release includes specifically:**

Office Notes                      Laboratory Reports  
Complete Record                Radiology Reports  
History & Physical               EKG                                      Other: \_\_\_\_\_

Covering records from:

- 1) The period from \_\_\_\_\_ to \_\_\_\_\_
- 2) Date of service \_\_\_\_\_

I UNDERSTAND THIS AUTHORIZATION MAY BE REVOKED IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE ON THIS AUTHORIZATION. UNLESS OTHERWISE REVOKED, THIS AUTHORIZATION WILL EXPIRE IN SIX MONTHS FROM THE DATE SIGNED, OR UNTIL THE FOLLOWING EVENT OR CONDITION:

\_\_\_\_\_  
\_\_\_\_\_

SIGNATURE (person authorizing release): \_\_\_\_\_

Date of Signature: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**A FEE MAY BE ASSESSED TO PROCESS YOUR REQUEST. PLEASE ALLOW FIVE BUSINESS DAYS TO RELEASE YOUR RECORDS**

