AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

This authorization must be written, dated and signed by the patient or by a person authorized by law to give this authorization.

I authorize _____ to release a copy of the medical information
(NAME OF HOSPITAL/HEALTH CARE PROVIDER)

For _____ to _____
(NAME OF PATIENT) (NAME AND ADDRESS OF RECIPIENT)

The information will be used on my behalf for the following purpose(s) _____

_____

By initialing the spaces below. I specifically authorize the release of the following medical records, if such records exist:

____ All hospital records (including nursing records
____ and progress notes)
____ Transcribed hospital records
____ Medical records needed for continuity of care
____ Laboratory reports
____ Pathology reports
____ Diagnostic imaging reports

____ Most recent five year history
____ Clinician office chart notes
____ Dental records
____ Physical therapy records
____ Billing statements
____ Other:

____ Please send the entire medical record (all information) to the above named recipient. The recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record.

____ HIV/AIDS related records *(Must be initialed to be included in other documents.)*
____ Mental health Information *(Must be initialed to be included in other documents.)*
____ Genetic testing information *(Must be initialed to be included in other documents.)*
____ Drug/alcohol diagnosis, treatment or referral information as listed on back. *(Federal Regulation, 42 CFR Part 2, requires a description of how much and what kind of information is to be disclosed. Provide a specific description of information on reverse of this form.)*

____ This authorization is limited to the following treatment: _____

____ This authorization is limited to the following time period: _____

____ This authorization is limited to workers' compensation claim for injuries of

_____ (Date).

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

_____ _____
(DATE) (SIGNATURE OF PATIENT OR PERSON AUTHORIZED BY LAW)