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GENERAL MEDICAL RECORDS RELEASE

Authorization for Use or Disclose of Protected Health Information

Please complete the following information:

Patient Name: _____ Medical Record Number: _____
 Date of Birth: _____ SSN: _____ - _____ - _____
 Address: _____ Phone: (_____) _____ - _____
 City, State, Zip: _____

I authorize the custodian of records of (healthcare provider/organization) _____

to disclose/release the protected health information described below* (check all applicable):

- All records
- Laboratory/pathology records
- X-ray/Radiology records
- Billing Records
- Abstract/Summary
- Pharmacy/Prescription Records
- Other (Describe Specifically)

*Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information as well.

These records are for services provided on the following date(s): _____

Please send the records listed above to (use additional sheets if necessary):

Name: _____ Name: _____

Address: _____

Address: _____

Phone: _____

Phone: _____

Fax: _____

Fax: _____

The information may be used/disclosed for each of the following purposes:

- At my request (only the patient can check this box).
- For my health care
- For payment/insurance
- For employment purposes
- Other (please specify): _____

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

 Signature of Patient (or patient's legal representative)

 Date

 Printed name of patient representative

 Representative's authority to sign (i.e., parent, guardian, executor)