



Request of Medical Information

1. Authorization: I authorize disclosure of medical information and health records as described below:

Name of Patient: _____ Date of Birth _____

Social Security Number: _____ - _____ - _____ Telephone (_____) _____
(Optional)

2. Record Holder: _____
(Hospital, Medical Group, or other Service Provider)

Street Address City State Zip

3. Records May Be Released To:

Street Address City State Zip

4. Type of Information: This authorization is limited to the following type(s) of information unless my initials appear beside each applicable category.

() Records Only () Labs () X-Rays () PT () Billing () MRI

Special Categories of Information: () Initial: HIV Information () Initial: Psychiatric Records
() Initial: Alcohol and/or drug abuse treatment

5. Dates of Service: From ____/____/____ To ____/____/____

6. Use of Information: The individual or entity identified above is permitted to use my information for the following purposes: **Please initial all that apply.**

___ Continuing Medical Care ___ Second Opinion ___ Personal
___ Insurance ___ Legal ___ Transfer of Care
___ Other (please specify) _____

[Type text]



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7. Duration: This Authorization is valid for one year from the date next to my signature, unless otherwise noted here: _____

8. Additional Copy: I further understand that I have a right to receive a copy of this authorization upon my request.

9. Re-disclosure: A statement that protected health information used or disclosed pursuant to the authorization may or may not be subject to re-disclosure by the recipient and thus no longer protected by the Privacy Rule.

10. Revocation: This authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. Written revocation will be effective upon receipt, but will not be effective to the extent that the Requester is specifically required or permitted by law.

11. Explanation: I understand that my treatment is no way conditioned on whether or not I sign the authorization and that I may refuse to sign it.

12. Patient Billing: I understand I will be billed \$15.00 plus \$.25 per page for personal requests.

13. Signature:

Printed Name: _____

Signature: _____ Date/Time: _____

If signed by other than patient, indicate relationship to patient: _____

Witness Signature: _____ Date/Time: _____