AUTHORIZATION TO RELEASE MEDICAL INFORMATION

RECORDS TO BE RELEASED FROM:

Business Name: _____

Address: _____

City, State Zip: _____

Telephone: _____ Fax: _____

I hereby request and authorize you to furnish records for the purpose of _____, or at my request. Release from _____ to _____. Labs Radiology Immunizations All

RECORDS TO BE SENT TO:

Business Name: _____

Address: _____

City, State Zip: _____

Telephone: _____ Fax: _____

PATIENT INFORMATION:

Patient Name: _____

Address: _____

City, State Zip: _____

Date of Birth: _____ Phone Number: _____

Social Security Number: _____

I understand that:

1. I may revoke this authorization at any time in writing, except to the extent that action has been taken based upon it;
2. The recipient of these records may further disclose this information and it may then no longer be protected by federal privacy regulations;
3. I am entitled to a copy of this document;
4. I may refuse to sign this authorization and my refusal to sign will not affect treatment, payment, enrollment, or eligibility for benefits;
5. There may be a charge for the release of these records pursuant to 45 CFR 164.524 (c) (4) (HIPAA);
6. This authorization shall expire upon my written request to revoke or according to state law; and
7. A copy of this authorization is as valid as the original.

_____ _____

Signature of Patient or Patient Representative Date

_____

Description of Representative's Authority to Act for Patient