Authorization for the release of patient information

Provider or facility records are being requested from:

Provider/facility: _____

Address: _____

City, state, ZIP code: _____

Phone #: (____) ____-_____ **Fax #:** (____) ____-_____

RE: Patient name: _____ **DOB:** ___/___/_____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

- ☐ Complete medical record, meaning every page in my record
- ☐ Office notes, consult notes, operative reports and hospital records
- ☐ Labs including, but not limited to, blood chemistry, pathology and histology
- ☐ X-rays and other imaging reports
- ☐ Pharmacy and prescription records
- ☐ Billing records

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This protected health information is disclosed for the purpose of: _____

You are authorized to release the above records to:

Name: _____

Address: _____

City, state, ZIP code: _____

Phone #: (____) ____-_____ **Fax #:** (____) ____-_____

I understand the following:

That I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization; that the information released in response to this authorization may be re-disclosed to other parties; and that my treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy, or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

_____ _____

Patient signature or legal representative **Date**

Optum