Medical Associates

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Authorization for Release of Medical Records

Patient's Name	Date of Birth	SSN
Address	Medical Record Number	Telephone Number

I AUTHORIZE THE USE AND DISCLOSURE OF HEALTH INFORMATION ABOUT SAID PAITENT AS DESCRIBED BELOW:	
Facility authorized to RELEASE Health Information:	Phone Number: Fax Number:
Agency or Individual(s) Authorized to RECEIVE Health Information:	Phone Number: Fax Number:

Health Information that may be used / disclosed is limited to the following:

- ☐ Discharge Summary
- ☐ Consultation(s)
- ☐ Pathology Report
- ☐ Lab
- ☐ History & Physical
- ☐ Operative Note(s)
- ☐ Imaging/X-Ray
- ☐ Entire Record
- ☐ Other(specify)

Health Information identifies you (the patient) by name, and includes other demographic information about you.

Health Information may include, but is not limited to: medical records, x-ray films, slides, tracings, strips, etc.

I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages and claims which might arise from the release of information authorized herein, to include alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnoses compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility.

Protected Health Information used of disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by this privacy rule. If research-related Health Information is used or disclosed for continued research purposes an expiration date or event does not apply.

This authorization will automatically expire in 60 days after the date below (except as indicated above), unless an earlier date is specified, or at the conclusion of a specified event. I understand that I have a right to revoke this authorization at any time, in writing, as stated in the Notice of Privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if the Health Insurance Portability Accountability Act prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with Health Insurance Portability and Accountability Act (HIPAA) privacy regulations.

Patient's or Authorized Personal Representative's Signature	Date	Time
Relationship to Patient / Authority to Act on Patient's Behalf	Witness Name	Witness Signature

THERE MAY BE A CHARGE FOR COPYING MEDICAL RECORDS.

PLEASE NOTE: If you are sending documents that total (20) pages or more, we ask that you use other means of transmission. (e-mail, CD, etc.)