

AUTHORIZATION AND CONSENT FOR RELEASE OF INFORMATION

I, _____, authorize and request

_____ to release to:
(Name of physician/practice)

_____ (Name and address of person or organization to receive information)

a complete copy of the medical records of _____, (Patient)

date of birth _____, Social Security Number _____,

from _____ (Date) to _____ (Date).

Reason for disclosure: _____.

I am aware that some of the health care information or other information contained in the requested medical records may be confidential or privileged, and I hereby specifically waive any privilege or confidentiality existing under federal or state law regarding such information including, but not limited to, protection afforded to:

1. AIDS Confidential information.
2. Medical information concerning alcohol an drug abuse.
3. Medical information.
4. Medical information concerning alcohol and drug dependency.
5. Medical information regarding mental issues.
6. Communications made to psychiatrist.
7. Communications made to a licensed applied psychologist.
8. Medical information concerning mental retardation.
9. Venereal disease and any other statutory protected diseases.

This authorization and consent is subject to revocation at any time, except to the extent that action has already been taken in reliance on it. If not previously revoked, this authorization will terminate 90 days from the date appearing below.

Date: _____ Signature: _____ (Patient or authorized person)

Witness: _____ Title: _____

NOTE TO RECIPIENT:

THE INFORMATION THAT HAS BEEN DISCLOSED TO YOU IS OR MAY BE PROTECTED BY STATE AND FEDERAL LAW. YOU ARE PROHIBITED FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER AUTHORIZATION IS OBTAINED OR DISCLOSURE IS OTHERWISE PERMITTED BY LAW. A GENERAL AUTHORIZATION FOR RELEASE OF INFORMATION MAY NOT BE SUFFICIENT.

This information requested was released to _____

on _____ via _____ (Mail, fax, courier) by _____.