

AUTHORIZATION TO RELEASE OR OBTAIN HEALTH INFORMATION

Authorization Date: _____

I understand that all information in the medical/health record of the individual recipient shown to the right is personal and private.

Recipient Name: _____

SSI: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

However, I hereby give permission for the facility shown right...

FROM: Facility: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

...to disclose my personal individually identifiable health information, shown below, to the facility/individual shown right...

TO: Facility: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

I am requesting the following medical records: CHECK ALL THAT APPLY **RECIPROCAL**

- | | | |
|---|--|--|
| <input type="checkbox"/> ENTIRE MEDICAL RECORD | <input type="checkbox"/> Diagnosis (es)* | <input type="checkbox"/> Hospital Records |
| <input type="checkbox"/> Physician Orders / Progress Notes | <input type="checkbox"/> Laboratory Test Results** | <input type="checkbox"/> Psychiatric Admission History |
| <input type="checkbox"/> History & Physical Exam | <input type="checkbox"/> Medication Records | <input type="checkbox"/> Psychosocial Assessment |
| <input type="checkbox"/> MENTAL HEALTH INFORMATION | | |
| <input type="checkbox"/> Other (specify): _____ | <input type="checkbox"/> For Date(s) of Service: _____ | |
| <input type="checkbox"/> Verbal Information Exchange between the Two Authorized Facilities Listed Above is Authorized | | |

* Including diagnoses related to alcoholism/drug abuse (Yes No) and/or Acquired Immunodeficiency Syndrome (AIDS)? (Yes No)

** Including lab tests related to alcoholism/drug abuse (Yes No) and/or Acquired Immunodeficiency Syndrome (AIDS)? (Yes No)

Purpose For Which Records Will Be Used: Treatment Clinical Evaluation/Assessment Psychiatric Evaluation Other (specify): _____

Manner In Which Records Will Be Released: Request that a **CONFIDENTIAL** copy of the records be **FAXED** to the "TO FACILITY" above **MAILED** to the "TO FACILITY" above

Expiration Of This Authorization: This authorization will expire _____ days weeks months from the date of my signature below, **OR** on this date ____/____/____ specified by me.

Signature(s) of Authorization

I understand that my records are protected by Federal Regulations. This Authorization for Release of Information may be revoked by me at any time except when the information has already been released and/or to the extent that action has been taken thereon. I further understand that this consent will expire upon the date specified on this authorization and cannot be renewed without my written consent. I certify that I am the recipient or the parent/guardian/legal representative of the recipient and have the legal authority to sign on behalf of the recipient whether by court order or by operation of law. I affirm that any questions I had about this form or the information it contains have been answered, and I believe I now understand all information/authorizations on this form.

Recipient / Legal Guardian – *Print*

Recipient / Legal Guardian – *Signature*

Date

Relationship to Recipient

OFFICE USE ONLY

You may receive a copy of this release upon request