Consent for Release of Medical Information

I hereby authorize the Practice, or any of its employees, staff, or agents, to use and disclose protected health information (PHI) from the medical record(s) of:

Patient Name:			
Address:			
(Street)	(City)	(State)	(Zip)
Date of Birth:	Medical Record #:		

REQUESTING RECORDS FROM:	WHERE TO SEND THE RECORDS TO:
Name/Facility:	Name/Facility:
Address:	Address:
City: State: Zip:	City: State: Zip:
Phone Number:	Phone Number:
Fax Number:	Fax Number:

Please Send Records from the following date range: From: To:

Initial all that apply:

I consent to have all the medical information regarding my treatment or hospitalization from my:

_____ Drug and alcohol treatment care
_____ Infection with human immunodeficiency virus (HIV) acquired immunodeficiency syndrome (AIDS)*
_____ Psychiatric care

**requires special consent*

I am requesting the following information to be released:

_____ Abstract of record (includes history and physical, operative-reports, consultations, discharge summaries, laboratory findings, radiology reports, and other significant findings)
_____ Entire medical record
_____ Other: _____ Labs _____ Slides** _____ X-rays**

*** I am aware that there are separate fees for and consents for X-rays, slides, and medical records, etc.*

This consent permits the Practice to use and disclose my protected health information to carry out treatment, payment, or healthcare operations. Additional information regarding the uses and disclosures of protected health information is described in the Practices notice of privacy practices. A patient has the right to review the "notice" prior to signing this consent. A patient has the right to request restrictions, uses, and disclosures of health information for treatment, payment, and healthcare operations purposes. However, the practice is not required to agree to a patient's request for restrictions. I may revoke this consent to release confidential information in writing, at any time, except to the extent that action has already been taken. No further confidential information is released without the execution of an additional written statement of authorization. I understand that these records are protected under federal and state law and cannot be disclosed without my consent unless otherwise provided by law. Having read the above information, I hereby *RELEASE, HOLD HARMLESS, AND AGREE NOT TO SUE* the practice, its employees, staff, and agents, in connection with the disclosure of information set forth relating to these medical records.

Print Patient's Name: _____

Signature of Patient: _____ Date: _____

Signature of Legally Authorized Person: _____