

MEDICAL RECORDS RELEASE FORM

1. I, _____ authorize _____ to use and/or
(patient name and D.O.B.) (name of Health Care Provider)
disclose the protected health information described below to _____.
(name of individual)

2. Authorization for Release of Information. Covering the period of health care from _____
to _____ **OR** _____ all past, present and future periods:

a. _____ I hereby **authorize the release of my complete health record** (including records
relating to mental health care, communicable disease, HIV or AIDS, and treatment of alcohol/drug
abuse).

OR

b. _____ I hereby **authorize the release of my complete health record with the exception of the
following information:**

- _____ Mental health records
- _____ Communicable diseases (including HIV and AIDS)
- _____ Alcohol/drug abuse treatment
- _____ Other (please specify) _____

3. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
4. This authorization shall be in force and effect until _____, at which time this authorization expires.
(date or event)
5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
6. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.
7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of Patient or Personal Representative

Date

Print Name of Patient or Personal Representative

Relationship to Patient