



# Authorization and Request for Release of Medical Information

1. Patient \_\_\_\_\_ Social Security Number \_\_\_\_\_  
Name – Last, First, MI (previous/maiden) (optional – for tracking purposes)  
 Street Address \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
 City, State, Zip \_\_\_\_\_ Phone Number ( ) \_\_\_\_\_  
 \_\_\_\_\_ Student ID Number \_\_\_\_\_

2. I authorize \_\_\_\_\_ to release to \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

3. Purpose or need for disclosure:  Further treatment  Other \_\_\_\_\_

4. Type or extent of information to be disclosed. **(Please specify and check applicable categories)**  
 Medical records pertaining to care for the period beginning \_\_\_\_\_ and ending \_\_\_\_\_  
 Allergy records \_\_\_\_\_  Female gynecological records \_\_\_\_\_  X-ray report(s) \_\_\_\_\_  
 \_\_\_\_\_  
 Laboratory report(s) \_\_\_\_\_  Progress note(s) \_\_\_\_\_  Other (please specify) \_\_\_\_\_  
 \_\_\_\_\_  
 Entire medical record \_\_\_\_\_  Immunization record(s) \_\_\_\_\_  
 \_\_\_\_\_

All records pertaining to **psychiatric/mental health, chemical dependence and/or HIV/AIDS related illness** will **NOT** be released unless specifically authorized in writing. This information is protected by federal law which prohibits any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation.

5. I specifically authorize the release of the following records:

<input type="checkbox"/> Psychiatric/psychological	_____	_____/_____/_____
	<small>Signature of patient or representative*</small>	<small>Date</small>
<input type="checkbox"/> HIV/AIDS related illness	_____	_____/_____/_____
	<small>Signature of patient or representative*</small>	<small>Date</small>
<input type="checkbox"/> Chemical dependency	_____	_____/_____/_____
	<small>Signature of patient or representative*</small>	<small>Date</small>

(\* If signature by other than patient, state relationship and authority \_\_\_\_\_ )

6. This authorization shall remain effective for 12 months after which time it will automatically expire without my express revocation. I may cancel this request with written notification at any time. A photocopy or fax copy of this authorization shall be granted the same authority as the original. The information disclosed may be subject to redisclosure by the recipient and no longer be protected by state or federal law or regulations.

7. I authorize release of my medical records in accordance with the specification listed above.

\_\_\_\_\_  
Signature of patient or representative\* \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Date

\_\_\_\_\_  
If signature by other than patient, state authority and relationship \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Date

**STAFF USE ONLY**

Chart # \_\_\_\_\_ Date received \_\_\_\_\_ Date released \_\_\_\_\_ Release approved by \_\_\_\_\_

Request verified by photo ID or matching signature

Released by:  mail  facsimile  to patient  certified mail  other \_\_\_\_\_