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AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

Please obtain medical records and information pertaining to medical history, mental or physical condition, service rendered or treatment of:

Patient Name: _____ DOB: _____

Address: _____

Phone: _____

Please **SEND** my medical information **TO**:

Name & Title of Provider/Organization

Records are available via fax through May 2027.

Street Address

City/State/Zip

Records available via mail through May 2037.

Phone Number

Fax Number

For the purpose of: Patient care Insurance claim Self Other

Description or nature of information to be used and/or disclosed:

The following (*) <u>must be initialed by the patient</u> to be included in the use and/or disclosure of other health information:	
___ *HIV/AIDS related information and/or records	___ *Mental Health Information
___ *Genetic Testing information	___ *Drug/Alcohol referral information

I understand that I may revoke this consent at any time provided that I do so in writing and except to the extent that action has already been taken.

This consent will expire as specified by (date) _____ or 60 days from the date of execution.

- I understand that I have the right to receive a copy of this authorization form.
- I understand that information disclosed may be subject to re-disclosure by the recipient.
- I give my permission for my medical information to be faxed to recipient.

Patient signature

Date

Signature of patient representative

Date