Release of Information Form

Patient Information:

Full Name: _____

Date of Birth: _____/_____/_____

Address: _____

Phone Number: _____-_____-_____

Email: _____

Healthcare Provider Information:

Name of Healthcare Provider/Facility: _____

Address of Provider/Facility: _____

Phone Number of Provider/Facility: _____-_____-_____

Fax Number of Provider/Facility: _____-_____-_____

Recipient of Information (who will receive the records):

Name of Person/Organization: _____

Relationship to Patient (if applicable): _____

Address: _____

Phone Number: _____-_____-_____

Email: _____

Purpose of Release (please check one or more):

□ Continuity of Care

□ Personal Use

□ Insurance Purposes

□ Legal/Medical Consult

□ Other: _____

Information to Be Released:

□ Medical Records (general)

□ Specific Medical Record (please specify): _____

□ Laboratory Results

□ Radiology Reports

□ Billing Information

□ Other: _____

Date Range of Information to Be Released (if applicable):

□ All Records

□ From: _____ To: _____

Expiration of Authorization: This authorization will expire on (date): _____ or upon the occurrence of the following event (if applicable): _____.

Rights and Acknowledgments:

1. I understand that I may revoke this authorization at any time by providing written notice to the healthcare provider, except where action has already been taken based on this authorization.
2. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on my providing this authorization.
3. I understand that information disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws.
4. I understand that I am entitled to a copy of this signed authorization for my records.

Patient/Legal Representative Signature:

Signature: _____

Date: ____/____/____

Relationship to Patient (if applicable): _____

Witness Signature (if applicable):

Signature of Witness: _____

Date: ____/____/____