



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please complete thoroughly. Your medical records cannot be released until this form is completely signed by the patient or legal guardian and returned to your providers office. There may be a processing fee of \$15.00 associated with this request.

PLEASE PRINT!!!! OR FILL OUT ONLINE AND PRINT AND SIGN

Patient Name: _____			Date of Birth ___/___/___		
_____	_____	_____	_____	_____	_____
Last		First		MI	
Address: _____					
_____	_____	_____	_____	_____	_____
Street			City		State Zip
Telephone : _____			Fax: _____		

I hereby authorize _____ MD/DMD to release my records.					
Physician's Address _____					
_____	_____	_____	_____	_____	_____
Street		City		State Zip	
Telephone: _____			Fax: _____		

Please release the following information for the purpose of (i.e. – transfer of care, special consultation, etc.)					
_____ All records _____ Dates of Treatment _____					
Send _____					
To _____					

Medical Fees are as follows: \$15 Base fee plus .50 for each page up to 100 pages & .25 cents for each page over 100 pages plus postage as applicable.					

<u>Signature Required</u>	
This authorization is valid for 1 year and may be revoked at any time in writing prior to the expiration date. Additional authorization for redisclosure beyond recipient is required.	
_____	_____
Patient's Signature	Date
_____	_____
Witness Signature	Parent/Guardian's Signature (If Patient is a minor)

<u>Release for Sensitive Information – Signature Required</u>	
I UNDERSTAND THAT IF MY MEDICAL RECORD CONTAINS INFORMATION IN REFERENCE TO DRUG AND/OR ALCOHOL ABUSE, PSYCHIATRIC, SEXUALLY TRANSMITTED DISEASES, SOCIAL SERVICE, HEPATITIS B TESTING/TREATMENT, AND/OR SENSITIVE INFORMATION, I AGREE TO ITS RELEASE.	
_____	_____
Signature of Patient or Legal Guardian	Date

<u>Release of HIV Information – Signature Required</u>	
IN ADDITION TO THE ABOVE SIGNATURES, IF YOU WANT YOUR HIV (AIDS) TESTING/TREATMENT RECORDS RELEASE YOU MUST SIGN AND DATE ON THE LINE BELOW.	
I AGREE TO THE RELEASE OF THIS INFORMATION	
_____	_____
Signature of Patient or Legal Guardian	Date