CONSENT TO RELEASE MEDICAL INFORMATION

Patient Name ____ **Date of Birth** _____________________
Address ____ **Phone**_____________________________
____ **Maiden Name** ____________________
Chart #

I hereby Authorize: Name of Provider____
Address____
____
Phone ______________________________ Fax ________________________________

To disclose the following medical information to:
Name of Provider____
Address____
____
Phone ______________________________ Fax ________________________________

Information to be disclosed: (This information will NOT be released unless the appropriate box is marked.)

_____ Any and all of my medical record (as of the date of this release)
_____ Limited Records Only: ____
_____ Mammogram Films
_____ Other (please specify: ____

This statement may be revoked, but not retroactive to the release of this information made in good faith. I understand that if my record contains items related to mental health (anxiety or depression), alcohol or drug usage (including tobacco), testing for sexually transmitted diseases, HIV or AIDS, it will be included as part of your request. These items will only be excluded if requested, in writing, on this form.

Reason for release: (please mark one)

- ☐ Changing medical doctors
- ☐ Consultation purposes
- ☐ Relocating
- ☐ Personal use
- ☐ Insurance
- ☐ Other: ____

____
Signature of Patient or Legal Representative

____
Date

OFFICE USE ONLY:

Mailed/ Faxed/ Picked Up Date: _______________ By: ______________________