



659 S. Salisbury Blvd.
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Outside Record Release or Disclosure of Health Information

Please print clearly

Patient Name: _____ Telephone: _____

Date of Birth: _____ Social Security Number: _____

Address: _____

	Records to be Released From:	Records to be Released To:
Name:		
Address:		
Telephone:		
Fax:		

Please send only the information checked below. Circle N/A if not available.

- ENTIRE CHART (N/A)
- LAST OFFICE NOTE (N/A)
- ALL TESTING FROM PAST 2 YEARS (N/A)
- ALL LABS (N/A)
- ALL IMAGING (N/A)
- ALL OPERATIVE AND PATHOLOGY REPORTS (including pre-op, post-op, and discharge notes) (N/A)
- Other _____ (N/A)

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my authorization for these records to be released unless specifically excluded. My initials below indicate records EXCLUDED from this authorization. The following information is NOT authorized for release:

- | | |
|---|--|
| <input type="checkbox"/> Drug/alcohol abuse/treatment and diagnosis | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> HIV/AIDS diagnosis/treatment/testing | <input type="checkbox"/> Mental Illness or psychiatric diagnosis/treatment |

I understand I do not have to sign this authorization in order to obtain healthcare benefits (treatment, payment or enrollment) and that I may revoke this authorization in writing at any time except to the extent action has been taken in reliance on this authorization. I understand that the information authorized for disclosure (except drug and alcohol treatment records) ay be subject to re-disclosure by the recipient listed above, at which time it may no longer be protected under federal HIPAA Privacy Rules.

Patient Signature: _____ Date: _____

This authorization will expire in 90 days