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MEDICAL RECORD RELEASE FORM

PATIENT NAME: _____ **DOB:** _____

PATIENT'S CURRENT ADDRESS: _____

RELEASE TO:	***RELEASE FROM:**
_____	_____
_____	_____
_____	_____

***Please list only one (1) clinic/ hospital per form**

INFORMATION TO BE RELEASED:

- ☐ **Complete Health Record**
- ☐ **Progress Notes Only**
- ☐ **Other:** _____
- ☐ **Lab/Radiology/Diagnostic Reports**
- ☐ **Immunization Records**

This information is being disclosed for the following purpose: ☐ Continuity of Medical Care

☐ Other Reason: _____

- I understand that I have the right to revoke this authorization at any time, which must be done in writing. I acknowledge that any revocation will not affect disclosures already made in response to this authorization. I am aware that my health record may contain information concerning sexually transmitted diseases, sickle cell disease, AIDS, HIV, and behavioral or mental health conditions.
- I certify that this request is voluntary, and that the information provided above is accurate to the best of my knowledge. I understand that I may choose not to sign this release and still receive treatment, authorize payments, and enroll in a health plan.
- I am aware that this authorization will expire on _____ [enter date] OR automatically expire in 6 (six) months from the date it was signed.

_____ _____
Signature of Patient OR Parent/Guardian OR Person Authorized to Sign for Patient **Today's Date**

_____
Relationship to Patient

Any information disclosed to you from our records is confidential and is protected by Federal law and all applicable state laws. Federal regulation 942C.F.R., Part 2 Prohibits you from making any further disclosure without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulation. A general authorization for the release of medical or other information is not sufficient for this purpose.