AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name:					
First Address:		M.I.	Last		
Patient Birthdate:	SS Number		Phone()	
Please OBTAIN information FROM	I the following:		Please SEND My Mo	edical Information TO :	
Name of Physician			Name of Person to receive information		
Name of Clinic/Hospital		Street Address			
Street Address		City/State/Zip			
City/State/Zip					
I authorize the above named facility to rel Purpose or Need for Data:	ease the following inform	nation:			
By initialing the spaces below, I spec	rifically authorize the r	elease of t	he following records,	if records exist.	
Please send entire medical record (a record may be voluminous and agrees to p					
All hospital records(including nurs	sing records and progress	notes)	Chart notes		
Transcribed records needed for continuity of care		Lab results			
Most recent five year history		Dental records			
Pathology reports		Other			
Radiology/imaging reports					
*HIV/AIDS related records			*Genetic testing i	nformation	
*Mental Health information *Must be initialed to be included in other	documents				
**Drug/alcohol diagnostics, treatm	ent or referral information	1			
**Federal Regulation 42 CFR Part 2 requ	ires a description of how	much and v	what kind of information	will be disclosed.	
This authorization is limited to the	following treatment:				
This authorization is limited to the	following time period:				
This authorization is limited to a we	orker's compensation clai	m for injur	es of:	(date).	
Consent may be revoked at any time. The revoked earlier, this consent will expire into complete the request.					
Date Consent Given		Patient/Parent or Legal Guardian			
Witness		Physician's Approval			

5/11/11