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Authorization for Release of Medical Records

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Patient Cell Phone: _____ Patient Home Phone: _____

Patient Insurance: _____

From: _____ Release To: _____

Any information which may be requested regarding my physical condition and treatment provided.

Specific Information to be Released: _____

Initial Below:

_____ General Authorization: I understand and acknowledge that this general information allows the health care facility to release all or part of the records indicated above for the purposes stated.

_____ Special Authorization: I understand that my medical records may contain alcohol/drug abuse or HIV/AIDS and/or psychological records. I also give my consent to release this information to the person or facility stated above.

This consent is valid for 90 days unless the release is revoked by me in writing before the release of information. I understand that in a transfer of records to another physician (unless for consult or insurance purposes), I am not a patient at Graham Medical Clinic.

Are you transferring your care to another physician? Yes _____ No _____

I have read this form or had it read to me, and I understand it. I was given the opportunity to ask questions and they were answered to my satisfaction.

My signature below indicates authorization for release of my medical records.

Signature of Patient: _____

If the patient is a minor or unable to sign for themselves:

Signature of designated individual: _____

Relationship to the patient: _____

Date: _____ Release Expires: _____