

**I AUTHORIZE PROVIDER TO RELEASE MEDICAL RECORDS INFORMATION****PROVIDE THE PATIENT'S INFORMATION:**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Email: \_\_\_\_\_ Phone: \_\_\_\_\_

**HOW WILL WE RELEASE THE INFORMATION (SELECT ONE OPTION)**

By Secure Email to Download Records (1 – 2-day delivery)  By Fax

By Mail\* (7 – 14 days delivery, dependent upon USPS)

\*Records exceeding 60 pages will be charged a fee of \$15.00

**WHO WE WILL RELEASE THE INFORMATION TO (SELECT ONE OPTION)**

Send Email Link To: \_\_\_\_\_  Fax To: \_\_\_\_\_

Mail To This Address: \_\_\_\_\_

City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**PROVIDE THIS INFORMATION ON THE RELEASE:****Dates of Service (Check One and Complete Dates of Service if Required)**

Please provide a complete copy of my file for service from \_\_\_\_\_ through \_\_\_\_\_

**Records to be Released (45 CFR § 164.508(c)).**

Entire Chart  Office Notes  Consults  Lab Reports  Radiology Reports  
 Imaging Films  Medications  Immunizations  Operative Reports  Physical Therapy  
 Itemized Billing  Other \_\_\_\_\_

**Purpose for Disclosure**

Continuing Care  Transfer of Care  Referring Physician  Disability  
 Legal/Attorney  Insurance  Other \_\_\_\_\_

**Please indicate your acceptance by checking the following boxes:**

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization (45 CFR § 164.508(c)(2)(i)).

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes (45 CFR § 164.508(c)(2)(ii)).

I understand that my records are confidential and cannot be disclosed without my written authorization except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) (45 CFR § 164.508(c)(2)(iii)).

This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reason if patient is unable to sign: \_\_\_\_\_  
(Provide guardianship, executor of estate, death certificate, or power of attorney paperwork with request)