

# AUTHORIZATION FOR RELEASE OF INFORMATION FROM MEDICAL RECORDS

I hereby authorize: \_\_\_\_\_  
Physician and/or Facility

\_\_\_\_\_  
Address

to release to:

\_\_\_\_\_  
Physician and/or Facility

\_\_\_\_\_  
Address

\_\_\_\_\_  
Relative or Significant Other

\_\_\_\_\_  
Address

The following information from the medical records for:

\_\_\_\_\_  
Patient Name

Date of Birth \_\_\_\_\_

\_\_\_\_\_  
Medical Records #

Daytime Phone # \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_ History/Physical Exam      \_\_\_\_ Lab Reports (including HIV test results)

\_\_\_\_ X-Ray reports                      \_\_\_\_ Progress Notes

\_\_\_\_ Other \_\_\_\_\_

The above information is being released for the following purpose and that purpose only. Any other use is forbidden.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance to it.

\_\_\_\_\_  
Signature of Patient

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Signature of Parent or other Responsible Party

\_\_\_\_\_  
Relationship to Patient

**PROHIBITION OR REDISCLOSURE.** This information is being disclosed to you from confidential records. As their confidentiality is protected by law, you are prohibited from making any further disclosure of this information except with the specific written consent of the person to whom it pertains and the facility from which the information originates.