

# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

*Please complete form thoroughly. Your medical records cannot be released until this form is completed and signed by the patient, or legal guardian.  
Please make a check mark in the box provided at left as you complete each step on the form.*

Step 1 Completed <input type="checkbox"/>	<p><b>STEP 1: Information about you: PLEASE PRINT!!</b></p> <p>Patient Name: _____ Date of Birth: _____  <small style="margin-left: 100px;">Last</small> <small style="margin-left: 100px;">First</small> <small style="margin-left: 100px;">MI</small></p> <p>Address: _____  <small style="margin-left: 100px;">Street</small> <small style="margin-left: 300px;">City</small> <small style="margin-left: 100px;">State</small> <small style="margin-left: 100px;">Zip</small></p> <p>Phone Number: _____ Alternate Phone: _____</p>
Step 2 Completed <input type="checkbox"/>	<p><b>STEP 2: Who has the records now? PLEASE PRINT!!</b></p> <p>I hereby authorize _____ M.D./D.M.D. (Circle one)</p> <p>Physician's _____</p> <p>Address _____</p>
Step 3 Completed <input type="checkbox"/>	<p><b>STEP 3: To whom do you wish to release your records? PLEASE PRINT!!</b></p> <p>I authorize release of the following information:</p> <p> <input type="checkbox"/> Complete Health Records      <input type="checkbox"/> Progress Notes Only  <input type="checkbox"/> Laboratory Reports            <input type="checkbox"/> Moh's Micrographic surgical notes  <input type="checkbox"/> Pathology Reports                <input type="checkbox"/> Consultation Reports  <input type="checkbox"/> Lab and Pathology Reports      <input type="checkbox"/> Other: _____                 </p> <p>Dates of Treatment: _____ to _____</p> <p>Release To: Name: _____</p> <p>Address: _____</p> <p>Phone #: _____ Fax #: _____</p>
Step 4 Completed <input type="checkbox"/>	<p><b>STEP 4: Your Signature</b></p> <p>This authorization is valid from 90 days and may be revoked at any time in writing prior to the expiration date. Additional authorization for redisclosure beyond stated time is required.</p> <p style="text-align: right;">_____ Patient's Signature</p> <p>_____ Witness Signature</p> <p style="text-align: right;">_____ Parent/Guardian's Signature</p>
Step 5 Completed <input type="checkbox"/>	<p><b>STEP 5: Release for Sensitive Information:</b></p> <p>I UNDERSTAND THAT IF MY MEDICAL RECORD CONTAINS INFORMATION IN REFERENCE TO DRUG AND/OR ALCOHOL ABUSE, PSYCHIATRIC, VENEREAL DISEASE, SOCIAL SERVICE, HEPATITIS B TESTING/TREATMENT, AND/OR SENSITIVE INFORMATION, I AGREE TO ITS RELEASE.</p> <p>_____ Signature of Patient or Legal Guardian</p> <p>_____ Date</p>
Step 6 Completed <input type="checkbox"/>	<p><b>STEP 6: Release of HIV Information:</b></p> <p>IN ADDITION TO THE ABOVE SIGNATURES, IF YOU WANT YOUR HIV (AIDS) TESTING/TREATMENT RECORDS RELEASED YOU MUST SIGN AND DATE ON THE LINE BELOW.</p> <p style="text-align: center;"><b>I AGREE TO THE RELEASE OF THIS INFORMATION</b></p> <p>_____ Signature of Patient or Legal Guardian</p> <p>_____ Date</p>