PATNO:_____

# Authorization for Release of Medical Records

Patient Name:_____ DOB:_____
Address:_____
City:_____ State:_____ Zip:_____
Phone:_____ Other:_____

I do hereby authorize the facility/provider specified below to disclose/release information from my health care record.

**DISCLOSE/RELEASE FROM:**

Facility Name:_____
Address:_____
City:_____ State:_____ Zip:_____
Phone:_____ Fax:_____

**DISCLOSE/RELEASE TO:**

Facility Name:_____
Address:_____
City:_____ State:_____ Zip:_____
Phone:_____ Fax:_____

This request and authorization applies to:

- ☐ Entire Medical Record
- ☐ Immunization Record
- ☐ Imaging/Radiology Results
- ☐ Lab Results
- ☐ History/Physical (most recent)
- ☐ Psychological Evaluation/Consults
- ☐ Psychotherapy Notes/ADHD
- ☐ Other:_____

Reason for request:

- ☐ Personal Use
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Specialist/Continued Care
- ☐ Transfer to new Physician
  Reason:_____
- ☐ Other:_____

I understand that any drug abuse, alcohol abuse, sexually transmitted disease, HIV/AIDS, psychotherapy or mental health related information, if present, will be disclosed with this authorization unless excluded here:_____

I understand that I may revoke this authorization, in writing, at any time, except to the extent that action has already been taken in reliance on this authorization. This authorization will remain in effect for 90 days in order to execute the purpose for which it is given unless earlier revoked in writing.

Signature of Legal Guardian:_____ Date:_____

Print Name of Legal Guardian:_____ Date:_____

Signature of Witness:_____ Date:_____