Patient Name _____Date of Birth_____

Address _____

Home Phone _____Cell Phone_____Fax:_____

I am requesting the release of my protected health information From:
Name _____

Address _____

Phone_____ Fax_____

Attention: _____

I am requesting the release of my protected health information To:
Name _____

Address _____

Phone_____ Fax_____

Attention: _____

I herby authorize the release of:

☐ Clinic Notes ☐ Lab Reports ☐ X-ray Reports ☐ Physical Therapy Notes

☐ Surgical notes ☐ Medication List

☐ **Complete Chart Excluding:** ☐ Mental Health ☐ Communicable Diseases (HIV , AIDS)
☐ Alcohol/Drug Abuse Treatment ☐ Other (Please Specify)

Dates of Service from _____ to _____ and/or Specific Condition_____

Reason for releasing information:

☐ Patient's request ☐ Transfer of Care ☐ Visit at Another Facility; date of visit_____

☐ Insurance Application ☐ Legal Other_____
(please specify)

This authorization shall be in force for 1 year from date of release or until _____
(Date)
at which time this authorization expires.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.
I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
Release of Protected Health Information my take 5-7 business days depending on clinic work load and number of pages requested.

_____ _____
*Signature of Patient or Legal Representative Date
*fully typed name constitutes my legal signature

_____ _____
Printed Name Relationship to Patient