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# Authorization for Release of Medical Records

**Patient Information:**

**Name:**

_____

_____

_____

**Date of Birth:**

_____

**Social Security Number:**

_____

**Request Release from:**

_____

_____

_____

I hereby authorize you to release to _____, a copy of my medical records to be used for continuing medical care. I reserve the right to revoke this authorization in writing at any time. Furthermore, I understand that this Protected Health Information may be re-disclosed by the recipient and thus, is no longer protected under privacy rules.

By signing this authorization, I understand that medical records released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drugs and alcohol abuse, etc. I understand that release of psychotherapy notes requires an additional authorization.

_____ _____

**Patient or Guardian Signature** **Date**

_____

**Patient or Guardian Printed Name**

**Please include the following items:**

- □ Admission Notes
- □ Progress Notes
- □ Discharge Summary
- □ Pathology Reports
- □ Operative Reports
- □ Consultations Notes
- □ EKG's
- □ Laboratory Tests
- □ X-Ray Reports
- □ Stress Tests
- □ Other: _____

Remarks: _____

This authorization will expire on _____

If left blank will be good for one year from date