AUTHORIZATION FORM - USE AND DISCLOSURE OF MEDICAL RECORDS

By signing this form, I authorize_____
(name of doctor, practice or other health professional)

to disclose the health information described below to:_____

_____
(name, address, phone and/or fax of health professional)

I am (check one): _____ Transferring care to the above named doctor

_____ Not transferring care – records for review only

Please send the following:

_____ All records (except HIV/AIDS, drugs/alcohol, mental health information**)

_____ Items requested by receiving party

_____ Selected items (please specify)_____

_____

(** Requires separate release form by law)

This release applies to:

Patient name(s)	DOB	Social Security #	Relationship to Signer

(** Please note that patients18 yrs and older require a separate release form)

This authorization expires upon _____ or until revoked.
(date)

I understand that I may refuse to sign this authorization. Treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned on signing an authorization (prohibited by state or federal law). I understand an authorization may be required to participate in research or where health care services are provided solely for the purpose of creating health information for a third party, and if I refuse to sign those services may be denied. I may revoke this authorization in writing by sending a letter by certified or return receipt requested mail to the administrator at the health care professional listed above. If I do, it will not affect previous actions already taken subject upon my prior authorization. I may not be able to revoke this authorization if it was used to obtain insurance. Once health information is disclosed pursuant to this authorization, it may be re-disclosed and may no longer be protected by privacy laws. The attached medical information is confidential and legally privileged as authorized by the patient. The recipient may not further disclose the information without the express consent of the patient as authorized by law.

_____
(signature) (date)

_____
(patient's address)

_____
(witness – relationship to signer) (date)

NOTE: This form must first be printed. Fill out, sign, date and send/fax to the party from whom you would like your records transferred.