

**Request for Access to/Authorization for Use and Disclosure of Protected Health Information  
Medical Record Release/Request Form**

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

DAY PHONE: \_\_\_\_\_ EVENING PHONE: \_\_\_\_\_

I hereby authorize: phone # \_\_\_\_\_

NAME (doctor or clinic): \_\_\_\_\_ Fax # \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY, STATE & ZIP: \_\_\_\_\_

to disclose my protected health information as indicated below to:

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY, STATE & ZIP \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

**Information to be released: check all that apply**

- |  |   |
|--|---|
| <input type="checkbox"/> Discharge Summary _____       | <input type="checkbox"/> Medication Records _____                 |
| <input type="checkbox"/> History & Physical Exam _____ | <input type="checkbox"/> Detailed Bill _____                      |
| <input type="checkbox"/> Progress Notes _____          | <input type="checkbox"/> Consult Notes _____                      |
| <input type="checkbox"/> Lab Reports _____             | <input type="checkbox"/> Other (specify content and dates): _____ |
| <input type="checkbox"/> X-Ray Reports _____           |   |

**PURPOSE OF DISCLOSURE:**

- Changing Physicians  Consultation  Insurance/Workers' Compensation  School  Research  At request of individual
- Legal (specify): \_\_\_\_\_
- Other (specify): \_\_\_\_\_
- For personal access (specify):  Copy  Inspection  Summary

**Please initial the following:**

- \_\_\_\_ I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
- \_\_\_\_ I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
- \_\_\_\_ By authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care.
- \_\_\_\_ I understand that if I am being requested to authorize a use or disclosure that I will get a copy of this form after I sign it upon request.
- \_\_\_\_ I understand my request will be acted upon within 30 days. If I am not provided access or information cannot be supplied, I understand I will be notified, and have the right to request review of any denial of access other than those made in accordance with applicable law.
- \_\_\_\_ I understand that I may be required to pay the cost of preparing and mailing copies, supervising my inspection, or preparing a summary except for uses and disclosures for the purpose of treatment, payment, and operations. The fee will not exceed current state limits.
- This authorization is effective this date: \_\_\_\_\_ thru \_\_\_\_\_ (dates must be specified)

Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

(Please check appropriate box)

I am the  Patient  Parent/Guardian of the Patient  Patient's Representative

(If this form was completed by someone other than the patient, please print name and address below.)

Name: \_\_\_\_\_ Address: \_\_\_\_\_

I understand that I have the right to receive a copy of this authorization.