Authorization for Release of Medical Information

As you complete each step on the form please make a check mark in the box provided at left
PLEASE PRINT

Step 1 Completed ☐	Step 1: Information about you: NAME: ____ Last First Social Security#______________________ Date of Birth: ______________ ADDRESS: ____ Street City State Zip TELEPHONE#: ( )____________
Step 2 Completed ☐	Step 2: Who has the records now? I here by authorize____ Family and Dr's name ADDRESS: ____ Street City State Zip TELEPHONE#: ( )____________
Step 3 Completed ☐	Step 3: To whom do you wish to release your records?: To release the following information: Please specify: ☐ ALL RECORDS OR ______________________ ☐ Dates of Treatment: From ____/_____/_____ To ____/____/_____ To: ____ Facility and Dr's Name Address: ______________________ City: ______________ State: _________ Zip: ___________ TELEPHONE#: ( )____________
Step 4 Completed ☐	Step 4: Your Signature: This authorization is valid for 90 days and may be revoked at any time in writing prior to the expiration date. Additional authorization for redisclosure beyond recipient is required. Patient's, Parent's or Guardian's Signature: ______________________ Date: ______________
Step 5 Completed ☐	Step 5: Release for Sensitive Information: **I understand that if my medical record contains information in reference to drug and/or alcohol abuse, psychiatric, venereal disease, social service, Hepatitis B Testing/Treatment, and/or sensitive information, I agree to its release.** Signature: ______________________ Date: ______________
Step 6 Completed ☐	Step 6: Release of HIV Information: **In addition to the above signatures, if you want your HIV (AIDS) testing/treatment records released, you must sign and date below.** Signature: ______________________ Date: ______________