AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Name of Patient	
Address	
Phone Number	E-mail
Birthdate	Last Four of Social Security Number
Other Aliases	

Name of Guardian or Legal Representative	
Address	
Phone Number	E-mail

I hereby authorize the following health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, prescription history clearing house, consumer reporting agency, employer, or family member to release all health information about me:

Person/Organization to Release Information		
Street Address		
City	State	Zip Code
Phone Number	Fax Number	

The following person/organization is hereby authorized to receive my entire medical record, treatment record and diagnostic record:

Person/Organization to Receive Information		
Street Address		
City	State	Zip Code
Phone Number	Fax Number	

The following health information that relates to service beginning from _____ to _____, may be released:

- Entire medical record (including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent by other health care providers)

I further understand that my medical record may include one or more of the following:

The above person/organization, its employees, representatives and any other persons performing services for them or on their behalf, may need to obtain, use or disclose any and all information about my physical and mental health, including but not limited to, services for preventative, diagnostic and therapeutic care, tests, counseling, and medical prescriptions for the purpose of:

I understand and agree that health information about me, which is used or disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient and may no longer be protected by law.

This authorization is valid . A copy, electronic copy, image, or facsimile of this authorization is as valid as the original. I have the right to revoke this authorization in writing at any time. I acknowledge that such a revocation is not effective to the extent the above person/organization has relied on the use or disclosure of my health information.

By my signature below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization.

I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my signature below. I am entitled to a copy of this authorization.

_____	_____	_____
Patient's Signature	**Patient's** Name	Date
_____	_____	_____
Guardian or Legal Representative's Signature	**Guardian or Legal Representative's** Name	Date