Health by Design
The way health care should work.

Authorization for Release of Medical Records

For Office Use Only

Records sent on: Initials:

PATIENT INFORMATION (Please Print)			
Patient Name	Date of Birth	Phone Number	
Address	City	State	Zip Code

RELEASE FROM: (Name of physician or facility releasing information)			
Physician/Facility	Phone Number	Fax Number	
Address	City	State	Zip Code

RELEASE TO: (Name of individual, physician or facility receiving information)			
Individual/Physician/Facility	Phone Number	Fax Number	
Address	City	State	Zip Code

RELEASE INFORMATION

Reason:
[ ] Continuity of Care [ ] Moving Out of the Area [ ] Legal
[ ] Change of Insurance [ ] Transfer of Care [ ] Personal File

Release the following:
[ ] Complete Medical Records [ ] Last Three Visits [ ] Lab Reports
[ ] Recent H&P [ ] X-Ray Reports [ ] Hospital Reports

CONSENT

I understand that my authorization will remain effective for one year from the date of my signature and the information will be handled confidentially in compliance with all applicable laws. I understand that I may see the information that is to be sent, and that I may revoke the authorization at any time by written, dated communication. The information released in response to this authorization may potentially be re-disclosed by the recipient to other parties and may no longer be protected by HIPAA.

My treatment cannot be conditioned on the signing of this authorization.

Please select the preferred format you want the requested records: _____ Compact Disc (CD) _____ Paper
_____ Encrypted Email

I authorize the release of all information indicated, and I am aware that the records released will contain personal health information.

Signature of Patient _____ **Date** _____