

# General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

## Please complete the following information:

Patient Name: \_\_\_\_\_

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

Phone: \_\_\_\_\_

SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

I authorize the custodian of records of: this entity \_\_\_\_\_  
to disclose/release the following information\* (check all applicable):

- All records
- Laboratory/pathology records
- X-ray/radiology records
- Billing records
- Abstract/Summary
- Pharmacy/prescription records
- Other (describe specifically)

*\*Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

These records are for services provided on the following date(s): \_\_\_\_\_

Please send the records listed above to (use additional sheets if necessary):

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

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

Phone \_\_\_\_\_ Phone \_\_\_\_\_

Fax: \_\_\_\_\_ Fax: \_\_\_\_\_

The information may be used/disclosed for each of the following purposes:

- At my request (only the patient can check this box)
- For my health care
- For payment/insurance
- For employment purposes
- Other:

This authorization shall expire no later than: \_\_\_\_/\_\_\_\_/\_\_\_\_ or upon the following event \_\_\_\_\_  
(whichever is sooner), and may not be valid for greater than one year from the date of signature for

\_\_\_\_\_  
Signature of patient or personal representative Date

\_\_\_\_\_  
Printed name of patient representative

\_\_\_\_\_  
Representative's authority to sign for patient, (i.e., parent ,guardian)