

Release of Information
Request



Patient's Name _____	Maiden/Former Name: _____
Patient's Address: _____	
City, State, Zip: _____	
Birth Date: _____	Social Security #: _____
Home Phone: _____	Other Phone: _____

I, Authorize: _____	To Release to: _____
_____	_____
_____	_____

The following information may be released: <input type="checkbox"/> Entire Medical Record <input type="checkbox"/> Specific Record From _____ to _____ <input type="checkbox"/> Immunizations <input type="checkbox"/> Billing Record <input type="checkbox"/> Only _____	Purpose of Disclosure: <input type="checkbox"/> Medical Care <input type="checkbox"/> Insurance <input type="checkbox"/> Attorney <input type="checkbox"/> Other _____
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	I consent to the release of the indicated sensitive, legally protected records (patient to initial). Mental Health Records..... _____ HIV or AIDS _____ Chemical Dependency..... _____	
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I understand that I may revoke this consent at any time by notifying the providing organization in writing, except to the extent that action has already been taken in reliance on it and that in any event this consent expires automatically in 180 days from the date of authorization.

I understand that the information disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Signature of Patient or Representative: _____	Date: _____
Printed Name: _____	Relationship to Patient: _____

I understand that Chemical Dependency client's/patient's records are protected by the Federal Law (42FR Part2) and cannot be disclosed without this written consent unless otherwise protected.