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Authorization to Release and Disclose Medical Information

PATIENT INFORMATION	NAME _____ DOB _____ ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE _____
RELEASE MEDICAL RECORDS FROM	<input type="checkbox"/> WHOLE LIFE HEALTH CARE (as above) or <input type="checkbox"/> NAME OF COMPANY _____ ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE _____ FAX _____
RELEASE MEDICAL RECORDS TO	<input type="checkbox"/> WHOLE LIFE HEALTH CARE (as above) or <input type="checkbox"/> PATIENT/ PARENT/GUARDIAN : <input type="checkbox"/> PICK UP OR <input type="checkbox"/> MAIL/ FAX <input type="checkbox"/> NAME OF COMPANY _____ ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE _____ FAX _____
MEDICAL RECORDS TO RELEASE	<input type="checkbox"/> MEDICAL RECORD ABSTRACT (Complete Record for last 3 years plus operative reports, imaging) <input type="checkbox"/> IMMUNIZATION RECORDS <input type="checkbox"/> LAST PHYSICAL EXAM <input type="checkbox"/> LABORATORY RESULTS <input type="checkbox"/> OTHER (specify record types) : _____
PURPOSE OF DISCLOSURE	<input type="checkbox"/> TRANSFERING CARE Reason: _____ <input type="checkbox"/> SHARING CARE <input type="checkbox"/> PERSONAL COPY <input type="checkbox"/> INSURANCE/ DISABILITY <input type="checkbox"/> LEGAL PURPOSES <input type="checkbox"/> FOR SCHOOL <input type="checkbox"/> OTHER : _____

I understand that the information I have agreed to release may include but is not limited to sensitive information such as: sexually transmitted disease, AIDS, HIV, behavioral or mental health services, alcohol drug abuse treatment, sexual preference, counseling/family problems. I agree to its release. If you DO NOT WANT this information released please specify what information should NOT be released: _____

I understand that:

- ~I can see and copy the health information described above.
- ~I can refuse to sign this authorization and that my refusal will not affect payment, eligibility for benefits or my ability to obtain treatment.
- ~Under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations.
- ~I can revoke this authorization in writing to the address above at any time, but my revocation will not apply to information that has already been disclosed or used in response to this authorization.
- ~ Consent expires one year from date signed

Patient / Legal Guardian Signature _____ **Date** _____

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