

Authorization to Release Medical Records

This document must be signed by the patient or person authorized by law.

I authorize _____ to release a copy of medical records
Health Care Provider/Hospital or Institution
for

Name of Patient _____

Date of Birth _____

Social Security Number _____

Other identifying information if applicable (other names) _____

Transmission by facsimile or electronic means authorized to expedite transfer of records.

Release medical records to:

Name _____

Address _____

Address _____

Phone _____

Fax _____

The information will be used on my behalf for the following purpose(s):

By initialing the spaces below, I authorize the release of the following records, if such exist:

- ___ Complete medical record (all information). The recipient understands that the entire record may be large and agrees to pay all reasonable copy charges.
- ___ All hospital/institution records (includes nursing records/progress notes)
- ___ Transcribed hospital/institution records (includes surgical reports, history/physical exam, consultation reports, discharge summary reports)
- ___ Laboratory reports
- ___ Pathology reports
- ___ Diagnostic imaging reports
- ___ EKG/cardiac reports
- ___ Physical/occupational therapy reports
- ___ Billing statements
- ___ Physician office/clinical records
- ___ Implant information (including operative report)
- ___ Photographs
- ___ HIV/AIDS records
- ___ Mental health testing
- ___ Drug/Alcohol diagnosis, treatment (Federal Regulation, 42, CFR Part 2, requires a description of how much and what kind of information is to be disclosed. Provide a specific description on the back side of the form.)
- ___ This authorization is limited to the following treatment

This authorization is limited to treatment for workers compensation injuries of

Date _____

Signature of Patient or Person Authorized by Law _____