

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

I hereby authorize the use or disclosure of my health information as described below. I understand the information disclosed under this authorization may be subject to redisclosure by the recipient and no longer be protected by federal privacy regulations:

Patient Name: _____ Date of Birth: _____
Address: _____ Phone #: _____
_____

Covering the period(s) of health care:From (date): _____ (date): _____,
and information to be disclosed (check all that apply)

___ Complete medical record(s) OR

Only:

___ History and Physical Examinations ___ Progress (Visit) Notes ___ Consultation Reports ___ Laboratory Tests
___ X-Rays Reports ___ Photos or Any other Imaging

This information is to be disclosed to (list name and address),

_____ _____

_____ _____

_____ _____

For the purpose(s) of: _____, or

☐ At the request of the patient

This authorization will expire 1 year from the date signed or sooner if a request is received in writing.

Signed: _____ _____
Patient Date

_____ _____
OR Legal Representative Date