MEDICAL RECORD RELEASE
Authorization for Disclosure of Health Information

Patient Name _____

Date of Birth _____

Street Address _____

City, State, Zip Code _____

I hereby authorize:

_____
Name of Individual or Entity

_____
Street Address

_____
City, State, Zip Code

To disclose my protected health information, as described below, to:

_____
Name of Individual or Entity

_____
Street Address

_____
City, State, Zip Code

Information to be released:

- ☐ Medical History
- ☐ Office Notes/Examination Reports
- ☐ Consultations
- ☐ Treatment/Tests
- ☐ Ultrasound Reports
- ☐ Hospital/Surgical Reports
- ☐ Laboratory Reports
- ☐ Sexually Transmitted Disease Results
- ☐ HIV Test Results (A listing of the statutory exceptions to release HIV test results without consent is available)
- ☐ Other: _____

Purpose for need of disclosure:

- ☐ Further Medical Care/Changing Doctors
- ☐ Second Opinion
- ☐ At the Request of the Individual
- ☐ Payment of Insurance Claim
- ☐ Application for Insurance
- ☐ Other: _____
- ☐ Legal Investigation
- ☐ Disability Determination

I understand that the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information might be re-disclosed without my authorization.

I understand that I have the right to:

- **Receive a Copy of This Authorization.**
- **Refuse to Sign This Authorization**; and that treatment, payment, enrollment in a health plan or eligibility for health care benefits may not be contingent on my signing this authorization.
- **Revoke This Authorization**, except to the extent that the person(s) and/or organization(s) listed above have already made in reference to this authorization.

This authorization will remain in effect until the following date(s): _____, or event: _____

_____ _____/_____/_____

Signature of Patient (or Legal Representative) **Date**

FVP_ Record Release – Rev. 10/12