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AUTHORIZATION TO RELEASE MEDICAL RECORD

PATIENT INFORMATION

Patient Name _____ Acct # _____

Birth date _____ Daytime Telephone _____

Address _____

Street City Sate Zip Code

I authorize the following organization to release information as state below from the patient health information record.

INFORMATION TO BE RELEASED FROM:

Organization/Person Name: _____

Address _____

Street City Sate Zip Code

Phone Number: _____ Fax Number: _____

INFORMATION TO BE RELEASED TO:

Organization/Person Name: _____

Address _____

Street City Sate Zip Code

Phone Number: _____ Fax Number: _____

TYPE OF INFORMATION TO BE RELEASED

1. GENERAL RELEASE

Type of Record

☐ *Medical Record, Excluding Protected Record (This will be limited to 2yrs of information including x-ray and lab report, unless otherwise stated)* _____ *to* _____

☐ *Lab Result* _____ *to* _____

☐ *X-Ray Result* _____ *to* _____

☐ *Other Record* _____ *to* _____

2. INFORMATION PROTECTED BY STETE/FEDERAL LAW

☐ *Drug Abuse Diagnosis/Treatment* _____ *to* _____

☐ *Alcoholism Diagnosis/Treatment* _____ *to* _____

☐ *Mental Health Diagnosis/Treatment* _____ *to* _____

☐ *Sexually Transmitted Disease Diagnosis/ Treatment or Counseling (AIDS/HIV)* _____ *to* _____

PATIENT AUTHORIZATION TO RELEASE MEDICAL IMFORMATION

_____

Date Signature of Patient or Legal Guardian Relationship to Patient