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INFORMED CONSENT - MEDICAL RECORDS RELEASE
AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS/PROTECTED HEALTH INFORMATION

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

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

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.

I, _____ hereby authorize _____ [physician name] to release the
records identified on Exhibit A to this Authorization for Release of Protected Health Information. I agree to be
responsible for all photocopying charges associated with the reproduction of such records.

This Authorization for Release of Protected Health Information applies only to the release of the records identified on
Exhibit A. Such records should be released to _____
[name and address of recipient] for the following purpose(s):

I understand that providing my authorization is voluntary. I need not sign this Authorization for Release of Protected
Health Information to continue to receive healthcare treatment from _____
[physician name]. I understand that I may revoke this authorization, in writing, at any time except to the extent that
disclosure was made prior to the time I revoked this authorization. I further understand that I may inspect and receive
copies of the information to be disclosed.

I understand that the health records and information disclosed, or some portion thereof, may be protected by the Federal
Health Insurance Portability and Accountability Act ("HIPAA"). I further understand that it is possible that the
information described above may be re-disclosed by the recipient and may no longer be protected by HIPAA. I further
understand that my records may be protected under state law and, if so, cannot be disclosed without my written consent
unless otherwise provided for in the law and/or regulations.

This Authorization for Release of Protected Health Information shall expire one (1) year from the date below. My
signature below acknowledges that I have read, understand, and authorize the release of the information described
on Exhibit A.

_____ Date: _____

[Name]

INFORMED CONSENT – MEDICAL RECORDS RELEASE
EXHIBIT A

DESCRIPTION OF HEALTH INFORMATION
SUBJECT TO AUTHORIZATION

By placing a check-mark in the spaces below, I authorize the release of the following records pertaining to services from _____ to _____ [insert dates]:

- _____ Pertinent medical record (all information)
- _____ All 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

Release of the following information may be governed by additional laws. I understand and agree that this information will be disclosed only if I place my **initials** in the applicable space next to the type of information:

- _____ HIV/AIDS information
- _____ Mental health information
- _____ Genetic testing information
- _____ Drug/alcohol diagnosis, treatment, or referral information