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RELEASE OF MEDICAL INFORMATION

Please only send information from the MOST RECENT YEAR the patient was seen

By signing this form, you permit the health care provider(s)/health plan(s) identified below to disclose your confidential personal health information.

Patient Name: _____ Date of Birth: _____

I am requesting information from the following doctor or facility:

Name: _____

Phone Number: _____ Fax Number: _____

You may use or disclose the following health care for my continued care:

_____All Records
_____History and Physical
_____Discharge Summary
_____Lab Reports
_____X-Ray/Radiology Reports
_____Emergency Room Reports
_____Consultation Report
_____Pathology Reports
_____Medication List
_____Mental Health

Exclusions:

_____

I understand that:

- **I can revoke this authorization at any time by giving my written revocation to the disclosing provider/plan.**
- **The disclosing provider/plan may not condition treatment, enrollment in the health plan or eligibility for benefits based on the signing of this authorization.**
- **I am authorizing disclosure of information protected under federal law. This information, once disclosed may be subject to re-disclosure by the recipient and is no longer protected by state or federal law.**

Signature: _____ Date: _____

This authorization has been revoked:

Signature: _____ Date: _____

Reason: _____