AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name:_____ ____ Date of Birth:_____ _____

Phone: (Home)_____ Phone: (Cell) _____

Address:_____ City/State/Zip: _____

Please Note: Copy Fee May Be Charged For Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: _____ Facility Phone:_____

Facility Address:_____ Facility Fax:_____
City, ST, Zip:_____

Please release the following:

___Entire Record

Or:

___Newborn Hospital Assessment Record; ___Laboratory Results; ___X-Rays; ___EKG Report
___EEG Reports; ___Operative Reports; ___Therapy Reports; ___Obstetrical Reports
___Psychological Reports;___ Most Recent History and Physical

___Other (specify) _____

Purpose of Disclosure:

___**Medical Care** ___**Insurance Purpose** ___**Legal Purpose** ___**Other**:_____

This information may be disclosed and used by the following individual or organization:

Release To: _____

Address: _____

City, State, Zip: _____

Fax:_____ Phone:_____

Please mail records____ Please fax records____

I understand that my medical record may contain information relating to acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in

response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization expires upon completion of this request or upon the following date:_____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR-164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about this disclosure of my health information, I can contact Ivy Children's Clinic.

___YES, I consent ___NO, I do not consent to the release of this information

_____ _____

Signature of Patient or Legal Representative Date

_____

Relationship to Patient

_____

Witness