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M E D I C A L R E C O R D S
RELEASE/REQUEST AUTHORIZATION

TO WHOM IT MAY CONCERN:

I, _____ , hereby give permission for medical information
(ENTER PATIENT NAME)
concerning my medical care to be: **(✓ CHECK OFF)**

❑ Requested from: ❑ Released to:

Requested Information:

❒ Lab(s) :	❒ All, ❒ Most recent	❒ Bone Density
❒ XRay(s):	❒ All, ❒ Most recent	❒ Echocardiogram
❒ Consultations:	❒ All, ❒ Most recent	❒ Colonoscopy
❒ Other: _____	❒ All, ❒ Most recent	❒ Mammogram

_____

(FACILITY/PHYSICIAN/AGENT)

_____

(ADDRESS)

_____

(CITY, STATE, ZIP)

_____

(TELEPHONE NUMBER) (FAX NUMBER)

I understand that information to be released may include information regarding drug abuse, alcohol abuse, psychological or psychiatric impairments, HIV, and/or AIDS or physical conditions. If information pertaining to drug or alcohol abuse or treatment of the same has been disclosed, it has been done so from records protected by Federal confidentiality rules (45 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by 42CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

_____ _____
(SIGNATURE OF PATIENT OR GUARDIAN) (DATE OF BIRTH)

_____
(ADDRESS, CITY, STATE, ZIP)

_____ _____
(WITNESS :SIGNATURE) (DATE)