MEDICAL RELEASE FORM

Patient Name: _____ Date of Birth: _____

Authorization to Release Medical Information:

I hereby authorize any physician, medical practitioner, hospital, clinic, pharmacy, or other medically related facility or provider having information regarding my health to release to the designated recipient(s) detailed below any and all medical information, records, and histories concerning diagnosis, treatment, prognosis, and payment for healthcare services, for the purpose of evaluation, treatment, insurance, or legal matters.

Recipient(s) of Information:

Name(s): _____

Address: _____

Phone Number: _____

Scope of Information to be Released:

I authorize the release of all medical records, including but not limited to: medical history, mental health records, HIV/AIDS-related information, substance abuse treatment records, laboratory test results, radiology images, billing and payment information, and any other pertinent health information.

Purpose of Disclosure:

The purpose of this disclosure is to provide necessary medical information for continuity of care, insurance processing, legal consultation, or as otherwise required by law.

Duration of Authorization:

This authorization shall remain in effect until revoked in writing by the patient or their legal representative. Revocation will not affect any actions taken prior to receipt of the revocation.

Right to Inspect and Copy Records:

I understand that I have the right to inspect and obtain a copy of the health information to be disclosed, upon written request to the provider releasing the information.

Redisclosure Notice:

I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations. However, the recipient is required by law to maintain the confidentiality of the information.

Refusal to Sign:

I understand that my refusal to sign this authorization will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits, except when my treatment is solely for the purpose of creating health information to be disclosed to a third party.

Signature of Patient or Legal Representative:

Signature: _____

Printed Name: _____

Relationship to Patient (if applicable): _____

Witness Signature:

Signature: _____

Printed Name: _____

Date: _____

Provider / Facility Information:

Provider Name: _____

Address: _____

Phone Number: _____

Acknowledgment and Understanding:

I acknowledge that I have read and understand this authorization form, and that I am signing it voluntarily. I understand that I may revoke this authorization at any time by providing written notice to the healthcare provider or facility listed above.

Patient Signature	**Witness Signature**
Signature: _____	Signature: _____
Date: _____	Date: _____