



# Release of Information

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NAME: \_\_\_\_\_ Birthday: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ Contact #: \_\_\_\_\_

\_\_\_\_\_ SSN #: \_\_\_\_\_

I hereby authorize and request release of my medical records:

PHONE or FAX

FROM: \_\_\_\_\_

TO: \_\_\_\_\_

**Information to be disclosed:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Discharge Summary                   | <input type="checkbox"/> EKG/EEG            | <input type="checkbox"/> CT/MRI/Ultrasound       |
| <input type="checkbox"/> History & Physical Exam             | <input type="checkbox"/> Echocardiogram     | <input type="checkbox"/> Vascular Study          |
| <input type="checkbox"/> Operative Report                    | <input type="checkbox"/> Holter Monitor     | <input type="checkbox"/> MRA                     |
| <input type="checkbox"/> Pathology Report                    | <input type="checkbox"/> Laboratory Results | <input type="checkbox"/> Emerg. Room Records     |
| <input type="checkbox"/> Clinic Notes                        | <input type="checkbox"/> Consult Notes      | <input type="checkbox"/> Psychiatric Information |
| <input type="checkbox"/> PT/OT Therapy Notes                 | <input type="checkbox"/> X-Ray Notes        |  |
| <input type="checkbox"/> Special x-ray reports (name): _____ |   |  |
| <input type="checkbox"/> Other (Name) _____                  |   |  |

Purpose of Release:  Medical Care  Personal Records  Attorney  Other

This statement of consent can be revoked at any time before disclosure of the information, and expires, in any event, six months after it is signed. Date of expiration: \_\_\_\_\_

I understand that I may revoke this authorization at any time before by notifying the providing organization in writing. If I revoke the authorization, it will not have effect on actions taken prior to receipt of this revocation.

I understand that the individual/institution that receives the information described above may not be covered by federal privacy regulations, and that the information may be re-disclosed publicly and no longer be protect by those regulations.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Signature of Parent/Guardian/Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship of person above to patient