

Authorization To Release Medical Records:

PATIENT INFORMATION:

Name (print) _____ DOB _____ SSN _____

INFORMATION TO BE RELEASED FROM:

Name of facility or provider _____

Address _____

INFORMATION TO BE SENT TO:

Name of designated recipient _____

Address _____ City _____ State _____ Zip _____

INFORMATION TO BE RELEASED: (check one)

- The most recent 2 years of pertinent information (chart notes, labs, x-rays and special tests)
 All medical records
 Specific information (please specify) :

PURPOSE FOR WHICH THE DISCLOSURE IS BEING MADE: (please check one)

Attorney Insurance Doctor Personal

PATIENT AUTHORIZATION :

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

* EXCLUDE the following information from the records released (please initial)

Drug / Alcohol abuse/treatment & diagnosis Sexually transmitted disease
 HIV/AIDS diagnosis/treatment/testing Mental illness or psychiatric diagnosis/treatment

MY RIGHTS:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

Signature: _____
(Patient, guardian*, or Authorized representative*)

Date: _____

**This authorization will expire 90 days from the date signed
Possible copying fee required**

Credit Card Payment Slip

Date Received _____ Initials of person taking CC pmt _____

Payment Information

Invoice # _____ Amount \$ _____

Credit Card information

Visa Master Card

CC# _____ - _____ - _____ - _____ Exp ____/____

Billing Zip Code for CC _____

Corporate Card? _____ If yes, please provide Customer Code _____

Contact Name _____ Contact Phone# _____

Would you like a receipt mailed to you?

Yes No

Is the mailing address on the invoice where you would like the receipt to be mailed? _____, if no please provide address below

Mailing Address _____

Printed Name on Credit Card _____