INFORMED CONSENT – MEDICAL RECORDS RELEASE

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS/PROTECTED HEALTH INFORMATION

This document must be signed by the patient or person authorized by law.

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Social Security Number: _____

Other identifying information if applicable (other names): _____
Transmission by facsimile or electronic means authorized to expedite transfer of records.

I, _____ hereby authorize _____ (physician name) to release the Records identified on Exhibit A to this Authorization for Release of Protected Health Information. I agree to be responsible for all photocopying charges associated with the reproduction of such records.

Cost of Photocopying: $25.00 for the first 20 pages and $.50 per page for every copy thereafter. Postal fees will be charged in addition to photocopy fees.

This Authorization for Release of Protected Health Information applies only to the release of the records identified on Exhibit A. Such records should be released to _____ _____ (name and address of recipient) for the following purposes._____ _____ _____.

I understand that providing my authorization in voluntary. I need not sign this Authorization for Release of Protected Health Information to continue to receive healthcare treatment from _____ _____ (physician name). I understand that I may revoke this authorization, in writing, at any time except to the extent that disclosure was made prior to the time I revoked this authorization. I further understand that I may inspect and receive copies of the information to be disclosed.

I understand that the health records and information disclosed, or some portion thereof, may be protected by the Federal Health Insurance Portability and Accountability Act ("HIPAA"). I further understand that it is possible that the information described above may be re-disclosed by the recipient and may no longer be protected by HIPAA. I further understand that my records may be protected under state law and, if so, cannot be disclosed without my written consent unless otherwise provided for in the law and/or regulations.

This Authorization for Release of Protected Health Information shall expire one (1) year from the date below. **My signature below acknowledges that I have read, understand, and authorize the release of the information described on Exhibit A.**

_____ _____

(Name) (Date)

INFORMED CONSENT – MEDICAL RECORDS RELEASE
EXHIBIT A

DESCRIPTION OF HEALTH INFORMATION
SUBJECT TO AUTHORIZATION

By placing a check-mark in the spaces below, I authorize the release of the following records pertaining to services from _____ to _____ (insert dates):

___ Complete medical record (all information)

___ All hospital/institution records (including nursing records/progress notes)

___ Transcribed hospital/institution records (includes surgical reports, history/physical exam, consultation reports, discharge summary reports)

___ Laboratory reports

___ Pathology reports

___ Diagnostic imaging reports

___ EKG/cardiac reports

___ Physical/Occupational therapy reports

___ Billing Statements

___ Physician office/clinical records

___ Implant information (including operative report)

___ Photographs

Release of the following information may be governed by additional laws. I understand and agree that this information will be disclosed only if I place my **initials** in the applicable space next to the type of information:

___ HIV/AIDS information

___ Mental health information

___ Genetic testing information

___ Drug/alcohol diagnosis, treatment, or referral information