



Authorization for Disclosure of Patient Information Please print or type. This authorization will not be valid unless all of the information is completed, including a valid signature and date.

I hereby authorize: (Facility/Dr): _____
Address _____ City _____ State _____ Zip _____
Fax # (_____) _____ Telephone Number (_____) _____

To release the medical record of: (Patient Name) _____
Address _____ City _____ State _____ Zip _____
Telephone Number: (_____) _____
Date of Birth: _____ SSN _____ Previous Name (if applicable): _____

SEND TO: Name _____
Address _____ City _____ State _____ Zip _____
Fax # (_____) _____ Telephone Number (_____) _____

The following information:
Progress notes, lab and x-rays for: (Choose One):
[] The last _____ year(s)
[] From _____ To _____
[] All Dates of Service
For Specific reports Choose below:
[] Lab Reports only for date(s) _____
[] X-ray Reports only for date(s) _____
[] Progress Note only for date(s) _____
[] Other (Specify) _____
* For Information Release ONLY - Do NOT fill out this form as it expires after 365 days. Fill out Privacy-Family/Other Communication Designation form*
For the following purpose:
[] Legal
[] Insurance (Claim) # _____
[] Insurance (Applying for Policy)
[] Patient Request - Personal
[] Patient Request - Moved
[] Patient Request - to Doctor/Medical Clinic
[] Other (please explain) _____
to convert to _____
You may be charged a fee for copies of \$.50/page + postage

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW
I hereby specifically authorize the release of data and information relating to: (check any that apply)
___ HIV/AIDS related testing
___ Mental Health (Including Behavioral Health and Sexual Health Clinics)
___ Chemical Dependency (Drug/Alcohol)

This authorization will be valid for 365 days from the date it is signed or until _____, whichever is shorter. This authorization may be revoked at any time by notifying the above named provider of information in writing, except when this authorization was obtained as a condition of obtaining insurance coverage. Any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. MHS and its affiliates cannot condition treatment or payment based on signature on authorization for disclosure. Information used/disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected.

Signature of Patient or Legal Guardian
(Parent/Legal guardian must sign if patient is a minor:
NE under age 19; IA under age 18)

FOR OFFICE USE: (for records sent through Dr Office)
Date Completed & Initials _____

Relationship to Patient, if not the Patient
(Legal Documentation Required for Legal Guardianship or Power-of-Attorney)

Date: _____