

AUTHORIZATION TO RELEASE PATIENT MEDICAL INFORMATION

I, _____, hereby authorize _____
to disclose health care information in the medical records of:

_____ Birth Date: _____
PRINT NAME OF PATIENT

INFORMATION TO BE **SENT TO:** **SENT FROM:**

NAME OF DESIGNATED RECIPIENT

ADDRESS

CITY, STATE, ZIP CODE PHONE NUMBER

WHAT KIND OF INFORMATION DO YOU WANT DISCLOSED? (CHECK ONE BOX)

Information from the most recent one year of visits. Information from Date: _____ to Date: _____.

SPECIFIC INFORMATION. PLEASE CHECK BOX:

| | | |
|--|--|---|
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> EKGs | <input type="checkbox"/> Immunizations |
| <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Problem Lists | <input type="checkbox"/> Consultations |
| <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Medication List | <input type="checkbox"/> Accounting of Disclosure |
| <input type="checkbox"/> Other (Please specify): _____ | | |

PURPOSE FOR WHICH DISCLOSURE IS BEING MADE:

Attorney Insurance Doctor Personal

PATIENT AUTHORIZATION:

You are authorized to release copies of my medical records. I understand that my records are privileged and confidential and I waive this status. I authorize release of all medical information, including psychiatric, drug and/or alcohol abuse records, the testing, counseling or treatment of AIDS, HIV or any sexually transmitted diseases and other confidential information. I understand I may be charged unless the records are being sent to another health care provider for the purpose of continuing care.

***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 get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study, or
- To resolve health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. To view the process of revoking this authorization, please read the Privacy Notice to our patients. I understand that once Overlake Medical Clinics discloses health information, the person or organization that receives it may re-disclose, at which time it may no longer be protected under Privacy laws.

| | | |
|------|--|---------------------|
| DATE | SIGNATURE OF PATIENT OR LEGALLY RESPONSIBLE PARTY* | RELATION TO PATIENT |
|------|--|---------------------|

(*Please provide documents to prove authority to sign on behalf of the patient)

If you desire a copy of this authorization, please notify a representative of the Medical Records department upon completion of this form. Authorization valid for only 90 days from signing this request. To be valid this form must be signed and dated.