## **AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION**

Name of Patient:	Phone Number:					
Other Names Used:	Date	of Birth:	h:			
I, the undersigned, authorize patient.	the release of or request acce	ss to the informa	tion specified belo	ow from the medical re	cord (s) of the above-named	
PATIENT INFORMATION IS	NEEDED FOR: PLEASE SELI	ECT ONE OPTION	ON			
☐ Continuing Medical Care	ical Care ☐ Military		rsonal Use	□ School	□ Insurance	
□ Legal Purposes	egal Purposes		☐ Other:			
DATE(s) OF TREATMENT:						
INFORMATION TO BE REL	EASED OR ACCESSED:					
☐ History & Physical ☐ Discharge/Deatl		Summary	ummary   □ Discharge Instructions			
□ Operative/Procedure Reports □ Radiology		ts	□ Clinic Notes			
□ Lab/Pathology Reports	□ Radiology Image	s	□ Immunizations			
□ Behavioral Health	□ Emergency Roor	n Record	□ Other		<del></del>	
☐ Consultation Report	☐ Face Sheet					
FORMAT REQUESTED FO	R INFORMATION TO BE PRO	VIDED:				
□ Paper □ Electronic me	edia					
METHOD OF DELIVERY:						
□ Pick Up (You will be notifi	ied via telephone call when rec	ords are ready)				
☐ Mail to Address listed belo	w Release to MyCha	rt account	□ Fax to			
□ Email to		@		Choose one:	: □ Encrypted □ Unencrypted	
	be sent by encrypted email un ormation could be accessed by		nerwise. By reque	esting unencrypted em	ail, I acknowledge that there	
			ı	May release the above	e information to:	
(Hospital/Facility/Practice Na	ame)			•		
(Name)						
Address (Street, State, Zip Code)				Phone Numbe	<u></u>	
Information used or disclosed that the specified information	s are confidential and cannot be d pursuant to this authorization to be released may include, bu ease, including Human Immund	may be subject to t is not limited to:	o re-disclosure by history, diagnose	the recipient and no loos, and/or treatment of d	nger protected. I understand drug or alcohol abuse, mental	
participation in research prog this authorization in writing a	or payment cannot be condition grams, or authorization of the rest at any time except to the extenting fee and for copies of my med	lease of testing that action has l	results for pre-emp been taken in relia	ployment purposes. I unce upon the authoriza	understand that I may revoke	
This authorization will expire unless otherwise specified by	One Hundred Eighty (180) day y date, event, or condition as fo			aless I revoke the autho		
Signature of Patient or Legally Authorized Representative		Printed Name	inted Name of Patient or Legally Authorized Representative Date			
For Department use: MRN/Acct #		Relationship to Patient				

HOSPITAL/FACILITY/PRACTICE NAME MUST BE FILLED IN BLANK BELOW





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PATIENT IDENTIFICATION

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