

APPENDIX

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(The execution of this form does not authorize the release of information other than that specifically described below)

TO:	PATIENT:	RELEASE TO:
(Print/type name & address of doctor or health care facility)	Name:	(Name & address of organization, agency, individual to whom information is to be released)
	S.S.No.:	
	Birth Date:	

I specifically authorize the release of information specified below to the organization, agency or individual named on this request.

Information Requested: _____

Copy of history & physical, discharge summary & operative Reports.

Copy of outpatient & E.R. admissions

Copy of complete medical records

Other (specify) _____

Conditions(s) and Dates of Care Covered:

All past admissions or care at this facility

Limited to treatment dates & for conditions described below:

Purpose(s) or need for which information is to be used:

Other

Injury or claim evaluation

Insurance or payer claim

Workers' compensation

Understand that the medical information released by this authorization may may not include information concerning treatment of mental illness, alcohol abuse and drug abuse.

I understand that authorization for disclosure of this health information is voluntary and I can refuse to sign this authorization. The above-named health care provider cannot condition treatment, payment, enrollment or eligibility for benefits on the signing of an authorization, except as otherwise permitted by law. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

EXPIRATION OR REVOCATION OF AUTHORIZATION - I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. If I am a minor, this authorization will expire on the date I become an adult according to state law. Without my previous written revocation, this authorization will automatically expire: _____ on _____ (date supplied by patient);

180 days from the date of my signature;

* Upon fulfilling the purpose or need for information as specified above, but no longer than _____ days (to be supplied by patient) from the date of signature; or

Under the following conditions, but no longer than _____ days (to be supplied by patient) from the date of signature.

*Note: Federal regulations require consent to release alcohol or drug records last no longer than reasonably necessary to serve the purpose for which the release is given.

Use of Copies: A copy of this authorization with my signature thereon may, may not, be utilized with the same effectiveness as an original.

Date	Signature of Patient	Person authorized to sign for patient
_____	_____	_____
		Print or type name:
		State how authorized: