**Patient Name**: **Date of Birth**: .

**Address**: **Apartment #**: .

**City**: **State**: **Zip Code**: **Phone #:** ( ) .

I hereby authorize the release of copies of my medical records as indicated below:

**FROM:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TO:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorization is limited to the following dates of treatment:

From: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Would you like to receive this information electronically? \***  Yes \_\_\_\_\_ No \_\_\_\_\_

**Email address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*There is a $6.50 fee for e-disclose.

**Information to be Used/Disclosed – Please check those that apply**:

History and Physical \_\_\_\_\_ Discharge Summary \_\_\_\_\_ Operative Report \_\_\_\_\_

Laboratory Report \_\_\_\_\_ Radiology Report \_\_\_\_\_ Immunization Record \_\_\_\_\_

Clinical Offices (Practice Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Protected Under State Law:**

**HIV/Communicable Disease** \_\_\_\_ I DO authorize \_\_\_ I DO NOT authorize

**Alcohol and/or Drug Abuse Treatment** \_\_\_\_ I DO authorize \_\_\_ I DO NOT authorize

**Mental Health Services** \_\_\_\_ I DO authorize \_\_\_ I DO NOT authorize

**Genetic Testing** \_\_\_\_ I DO authorize \_\_\_ I DO NOT authorize

**(**Mental Health Services provided by**:** a clinical nurse specialist; psychologist; social worker; counseling professional; or a physician specializing in psychiatry licensed under the provision of Title 32.)

**The Purpose for releasing this information is:**

Attorney/Legal Case \_\_\_\_ Personal Use \_\_\_\_

Further Medical Care\_\_\_\_ Transfer of Care (2 years of records sent unless otherwise specified) \_\_\_\_\_

Disability/Insurance Application/Claim \_\_\_\_ Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I understand** I may revoke all or part of this authorization by notifying CMHC. This authorization will be retained as part of my medical record. I may refuse to disclose all or some of the information in my medical record. A refusal or revocation to release some or all information may result in improper diagnosis or treatment, denial of insurance coverage or claim for health benefits, or other adverse consequences. I may cross out any words on this authorization with which I disagree. I may have a copy of this authorization upon request. I understand that if this information is disclosed to a third party, the information may no longer be protected by the federal privacy regulations and may be re-disclosed by the person or organization that receives the information. If I refuse to sign this authorization, I understand my records will not be released. There may be a charge for the processing of records. CIOX may handle the release of medical records. It may take up to 30 business days to complete request – 60 days fi the records are in storage. For billing questions, please call 1-800-367-1500.

**This authorization will expire 90 days from the date I sign this form.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Patient or Legal Representative Relationship to patient Date**

**\*\* For Office Use Only \*\***

Employee accepting request: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID Checked \_\_\_YES \_\_\_\_ NO

Request Completed By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_