Grace Health

Authorization for Release of Medical Information

Patient Name: _____
First Middle Last

Date of Birth: _____

Previous Names Used: _____

Address: _____ **Phone Number:** _____

I authorize the release of information as follows:

From: _____
Person/Entity authorized to disclose this information

_____
Address

_____
City State Zip

_____
Phone/Fax Number

To: _____
Person/Entity authorized to receive this information

_____
Address

_____
City State Zip

_____
Phone/Fax Number

Specific information to be released – From Date: _____ **To Date:** _____

I request the following information to be released, which may include alcohol and drug dependency or abuse, mental health treatment, and / or testing, care, treatment, reporting, or research pertaining to infection with HIV or AIDS.

❑ Lab Results ❑ Radiology Reports ❑Prenatal ❑Behavioral Health

❑ Dental ❑ GYN ❑Immunizations ❑Medication List

❑ Other (Specify) _____

_____

Purpose for release:

❑ Transferring care to another provider ❑ Other: _____

❑ At the request of the patient/legal representative

I understand there is a possibility the information may be redisclosed by the recipient and no longer protected under the federal privacy rules. I understand this is an optional form and my refusal to sign it will not affect my ability to obtain treatment and I may obtain a photocopy of this form on request.

This release is effective for one year from the date of execution; however, it may be revoked by me at any time by providing written notice to the above named party. A facsimile or photocopy of this document will be accepted in lieu of the original.

_____ _____

❑ Patient/Legal Representative ❑ Parent ❑ Guardian Date

_____ _____

Witness Date