



AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records.
 Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

AUTHORIZATION

I hereby authorize: _____
 Physician/Healthcare Facility

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records by means of mail, fax or other electronic methods.

To: _____
 Name

 Address City State Zip Code

 Telephone Fax #

The medical information/records will be used for the following purpose: _____

This authorization is:
 Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)
 Limited to the following medical information: _____

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse _____ (initial) Tests for Antibodies to HIV _____ (initial)
 Psychiatric/Mental Health _____ (initial) HIV Diagnosis/Treatment _____ (initial)

DURATION This authorization shall be effective immediately and remain in effect until _____
 Date

RESTRICTIONS
 Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy of facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

 Signature of patient or legal/personal representative Relationship if other than patient Date

 Patient's Name (PRINT) Patient's Social Security Number Patient's Date of Birth

 Witness name Witness signature

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