AUTHORIZATION TO DISCLOSE/RELEASE OR OBTAIN MEDICAL RECORDS

*All disclosures are in compliance with Federal and State laws, including the Health Insurance Portability and Accountability Act of 1996 (**HIPAA**), governing the use and disclosure of Protected Health Information (PHI).*

I hereby authorize to: ☐ **disclose/release to:**
☐ **obtain from:**

(name of person or organization)		
(address)		
(city)	(state)	(zip)
(telephone)	(fax)	

INFORMATION REQUESTED:

I hereby agree to this authorization and understand that it must contain Personally Identifiable Information and PHI as defined by **HIPAA** to ensure accuracy. I understand I have the right to limit the type of information released and to revoke this authorization by submitting a notice, in writing, to the medical groups Privacy Officer. Unless revoked, this authorization will expire one year from date of signature or on the following date _____. If I choose to limit the information released, I understand that the medical group may inform the requestor that portions of the record have been withheld. I understand the information disclosed may be subject to re-disclosure by the recipient and no longer be protected by this medical group. The medical group and its staff are hereby released from any legal responsibility or liability for disclosure of the below information to the extent indicated and authorized herein.

☐ **ALL medical records** without exception, including: clinical notes, lab testing (including HIV), mental health treatment, alcohol or drug abuse testing & treatment, sexually transmitted disease, consultations, secondary **records**, etc.

or:

☐ **PARTIAL medical records** which may include HIV testing & treatment, mental health treatment, alcohol or drug abuse testing & treatment, sexually transmitted disease & other sensitive information. Please specify parts and dates to be released:

- □ progress notes_____ (□ all dates)
- □ x-ray reports_____ (□ all dates)
- □ immunizations _____ (□ all dates)
- □ psychology notes_____ (□ all dates)
- □ lab reports _____ (□ all dates)
- □ gyn records _____ (□ all dates)
- □ operative notes_____ (□ all dates)
- □ consultations _____ (□ all dates)
- □ other (specify)_____ (□ all dates)

I authorize the release of my medical records as indicated above. **X**_____

(name of person or organization)	(ss#)	(date of birth)
(address)		
(city)	(state)	(zip)

Note to Recipient: This information has been disclosed to you from **records** whose confidentiality is protected by Federal and State laws (including **HIPAA**) and prohibits you from further disclosure without the written consent of the person to whom it pertains. Charges may apply for copies of **medical records**.

A copy of this form will be filed in the above-named patient's PHI