CONSENT FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the practice, or any of its employees, staff or agents to use and disclose protected health information (PHI) from the medical record(s) of:

Patient name: _____

Address: _____

(Street) (City) (State) (Zip)

Date of birth: _____ medical record number: _____

Date(s) of treatment: _____

Release of information to (name of individual or organization):_____

_____

Address: _____

(Street) (City) (State) (Zip)

Initial all that apply:

I consent to have all the medical information regarding my treatment or hospitalization from my:

_____ General hospitalization or outpatient care

_____ Drug and alcohol treatment care

_____ Infection with human immunodeficiency virus (HIV) acquired immunodeficiency syndrome (AIDS)*

_____ Emergency room visit

_____ Psychiatric care

*requires special consent

I am requesting the following information to be released:

_____ Abstract of record (includes history and physical, operative reports, consultations, discharge summaries, laboratory findings, radiology reports and other significant findings)

_____ Entire medical record

_____ Other _____ Labs _____Slides** _____X-rays**

**I am aware that there are separate fees for and consents for X-rays, slides, medical records, etc.

CONSENT FOR RELEASE OF MEDICAL INFORMATION (CONT.)

I permit this confidential information to be released for the following purposes:

_____ Continuing medical treatment

_____ Litigation for review

_____ Insurance (company name): _____

_____ Other (specify reasons): _____

This consent permits the practice to use and disclose my protected health information to carry out treatment, payment or healthcare operations. Additional information regarding the uses and disclosures of protected health information is described in the practice's Notice of Privacy Practices. A patient has the right to review the "notice" prior to signing this consent. A patient has the right to request restrictions, uses and disclosures of health information in writing, at any time, except to the extent that action has already been taken. No further confidential information is released without the execution of an additional written statement of authorization. I understand that these records are protected under federal and state law and cannot be disclosed without my consent unless otherwise provided by law. Having read the above information, I hereby RELEASE, HOLD HARMLESS AND AGREE NOT TO SUE the practice, its employees, staff and agents in connection with the disclosure of information set forth relating to these medical records.

Print patient's name: _____

Signature of patient: _____

Signature of legally authorized person: _____

Date: _____