Memorial MEDICAL GROUP

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: **Date of Birth:**

AUTHORIZATION: I hereby authorize _____ to release/disclose the above named individual's health information. The applicable contents and purpose for disclosure is selected below: *(check all that apply)*

Date(s) of Service:

CONTENTS:

- ☐Entire Record
- ☐Assessment/History and Physical
- ☐Discharge Summary
- ☐Lab Tests
- ☐Radiology Reports
- ☐Behavioral/Mental Health Visits
- ☐Other:_____

PURPOSE:

- ☐Insurance/Third Party reimbursement
- ☐Continuity of care
- ☐Pending legal matter
- ☐At the request of the patient
- ☐Other:_____

I understand that the information in my medical record may include information relating to sexually transmitted disease and acquired immunodeficiency virus (HPV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. I understand that by signing this authorization I am authorizing the release of such information unless specified otherwise.

THE INFORMATION IS TO BE RELEASED TO:

Name:

Address:

Fax Number:

Patient is aware of confidentiality risks involved and releases Memorial Medical Group of responsibility of this fax transmission.

RESTRICTIONS: According to the Federal and State regulations, if the medical information requested relates to AIDS/HIV or treatment in a federally-recognized chemical dependency unit, then the information will be accompanied with a statement limiting disclosure to third parties as required by law.

I understand that if the person or entity that receives the requested information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.

DURATION: This authorization will remain valid for 1 year from the date below. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to my authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent a claim under my policy.

Signature (Patient or Legal Representative):	**Date:**