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Medical Records Release

Patient Name: ______________________________________ SS#: ___________________

Persons/Organization providing the information:	Persons/Organization receiving the information:

Specific description of the information including date(s):

The information described above will be used or disclosed for the following purposes:

Expiration Date:
This authorization will expire: ☐ 60 days ☐ 90 days ☐ other ___________ from the date signed.

I understand and authorize the release of my medical records and other information regarding my treatment, including mental illness or psychiatric treatment, drug abuse, alcolism, acquired immunodeficiency syndrome (AIDS) or other sexually transmitted diseases or infections. I can at any time revoke this consent by doing so in writing, but the withdrawal of authorization cannot be retroactive to the release of information made in good faith.

We keep a record of the medical services we provide you. You may ask to see and copy that record. You may also ask to have the copy amended. We will not disclose your record to anyone unless you direct us to do so or unless law requires us to do so.

____ ________________________
Signature of patient or patient's representative Date

Printed name of patient's representative: ____

Relationship to patient: ____