AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I HEREBY AUTHORIZE THE RELEASE OF INFORMATION FROM THE MEDICAL RECORD OF:

PATIENT NAME: ______________________________________ DOB:___________________

Social Security: __________________ Daytime Phone___________________

Information Released From: **Facility**____

____

Phone:____

Fax:____

Information Requested To: **Facility:**____

____

Phone:____

Fax:_ ____

Please release the following: (DRAW A LINE through any records you do NOT want sent)

- Progress Notes - Problems List - History/ Physical Exams
- Lab Reports - Immunization Radiology Reports - ER/ Hospitalization Records
- Other diagnostic report, notes from other Primary Care Physicians
- Notes from Doctors to whom the patient has been referred
- Information pertaining to Mental Health, HIV/ AIDS, other STDs, other communicable diseases
- Other (be specific): ____

Dates of treatment: __________________ to ______________ OR **xxxx** **ALL DATES**

Purpose or need for disclosure:

___ Continued Patient Care x ___ Personal Use
___ Attorney/ Legal ___ Insurance Claim/ Application
___ Disability Determination ___ Other (specify) _____________

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it. This consent will expire in 120 days after the date of my signature unless otherwise specified.

IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:

I understand that my medical record may contain reports, test results, and notes that only my physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical records to prevent my misunderstanding of the information contained in these entries. I will not hold COPPELL ASSOCIATES IN FAMILY MEDICINE, P. A. liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

Signature of Parent or Legal Representative Date