AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

AUTHORIZATION

I hereby authorize:

Physician/Healthcare Facility

To release information on (Patient’s Name)

(Patient’s DOB) regarding my medical history, illness or injury,

consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other healthcare providers that the above named healthcare provider may hold, by means of mail, fax, or other electronic methods.

To:

Name

Address

City State Zip Code

The medical information/records will be used for the following purpose:

This authorization is:

[ ] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV

Diagnosis/Treatment)

[ ] Limited to the following medical information:

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