AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

________________________________	________________________________
(Print **patient's** full name)	Birth date (Mo/Day/Yr)
________________________________	________________________________
(Street address)	Social Security Number
________________________________	________________________________
(City, state, zip code)	Phone (Home)

At the request of the individual, I ___________________________, do hereby authorize ___________________________
(Patient Name) (Practice Name)
________________________________to release:

_____Medical History	_____Radiology Reports	_____Immunization Records
_____Progress Notes	_____EKG Results	Other_________________________
_____Laboratory Reports	_____Other Ancillary Reports	_________________________

_____I do _____I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO: ________________________________
Name of Company/Agency/Facility/Person

____
Street address

____
City, state, zip

PURPOSE OF DISCLOSURE:
_____REFERRAL TO SPECIALIST _____INSURANCE _____WORKERS COMP _____CHANGE OF DOCTOR
_____LEGAL INVESTIGATION _____DISABILITY DETERMINATION _____PERSONAL
OTHER (SPECIFY)____

Please provide a DAYTIME telephone number in the event we need to contact you:________________________________

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 90 DAYS from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

________________________________	________________________________
Signature of individual (or guardian or Personal Representative of patient's estate)	**Date**

MEDICAL INFORMATION RELEASED

Medical History______	Radiology Reports_____	Immunization Records_____	________________________
Progress Notes_______	EKG Results__________	Other_________________________	ROI SPECIALIST
Lab Reports__________	Other Ancillary Rpts____	_________________________	________________________
			DATE

A PHOTOCOPY OF THIS RELEASE IS VALID AS THE ORIGINAL.