Authorization to Disclose Medical Records

This authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization.

I authorize (name of health care provider) _____

_____

_____

To release a copy of medical information for (patient name) _____ to

(Name of heath care provider) _____

_____

_____

By initialing the spaces below, I specifically authorize the release of the following dental/medical records if such records exist.

_____ Dental records/dental x-rays

_____ Billing Statements

_____ Clinician office chart notes

_____ Other

_____

_____ This authorization is limited to the following treatment

_____

_____ This authorization is limited to the following time period

_____

** Federal Regulations, 42 CFR Part 2, requires a description of how much and what kind of information is to be disclosed.

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

_____ _____

(Signature of patient) (Date)

_____ _____

(Signature of person authorized by law) (Date)