AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

FROM: Patient's Name_____

Date of Birth_____ Social Security #_____

I. CHOOSE ONE (*Place an "X" to indicate your choice*):

☐ Send records to whom: ☐ Dr. ☐ Mr. ☐ Ms._____
{Address}_____
{Address}_____

☐ Patient (self) will pick up a copy of the medical records.

☐ Patient will allow ☐ Mr. ☐ Ms. _____ to pick up a copy of records.

☐ Fax records to Attention: ☐ Dr. ☐ Mr. ☐ Ms. _____. Fax number to fax is: (_____) _____-_____

II. CHOOSE ONE (*Place an "X" to indicate your choice*):

☐ Send **all** of my records, **including** notes related to HIV testing, AIDS, AIDS-related syndrome, sexually transmitted diseases, alcohol/drug/substance abuse.

☐ Send **all** of my records FROM {DATE} _____/_____/_____ TO {DATE} _____/_____/_____, **including** notes related to HIV testing, AIDS, AIDS-related syndrome, sexually transmitted diseases, alcohol/drug/substance abuse.

☐ Send part of my record, **except for** notes related to HIV testing, AIDS, AIDS-related syndrome, sexually transmitted diseases, alcohol/drug/substance abuse.

III. This information for which I am authorizing disclosure will be used for the following purpose: (*Place an "X" to indicate your choice*):

☐ my personal records
☐ sharing with other health care providers as needed
☐ other (please describe):

IV. CONSENT AND AUTHORIZATION

I hereby consent and authorize ID Consultants, PA to release copies of my medical records including current and previous medical records from other practices and practitioners, hospitals, and/or clinics which are a part of my medical records, I agree to indemnify and release ID Consultants, PA from any liability resulting from this release.

_____ _____ _____
Patient Signature Date Witness

V. *I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing, except to the extent that ID Consultants, PA has already used or disclosed information in reliance on this authorization. Unless revoked earlier or otherwise indicated, this Authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request. Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient until this authorization is revoked or expires.*