



REQUEST AND CONSENT FOR RELEASE OF MEDICAL RECORDS

Patient _____
Address: _____

Date of Birth _____
Med Rec# _____
Phone _____

I hereby authorize and direct _____ to furnish
to _____ phone _____
at _____ fax _____

the following information from my medical record (please check type of record below)

Type of Record Requested	Date	Type of Record Requested	Date
<input type="checkbox"/> Hospital Inpatient		<input type="checkbox"/> Outpatient/Clinic	
<input type="checkbox"/> Emergency Services		<input type="checkbox"/> Skilled Nursing/ICF	

I authorize the following information to be released (please check)

<input type="checkbox"/> Complete Record	<input type="checkbox"/> Radiology Reports
<input type="checkbox"/> History & Physical Exam	<input type="checkbox"/> Consultation Report
<input type="checkbox"/> Emergency Room/Outpatient Services	<input type="checkbox"/> Progress Notes
<input type="checkbox"/> Operative Report	<input type="checkbox"/> EKG/EEG Interpretations
<input type="checkbox"/> Immunizations	<input type="checkbox"/> Discharge Summary or Final Diagnosis
<input type="checkbox"/> Lab/Pathology Reports	<input type="checkbox"/> Physical, Occupational or Speech Therapy
<input type="checkbox"/> Only the information deemed necessary as stated in the purpose for release.	<input type="checkbox"/> Other (please describe)

The Information being disclosed may be used only for the following purposes (please specify)

- Payment or Reimbursement Utilization Review Continuation of Care
 Other-specified here _____

Information furnished in the form of (please circle one) Copies Mail Fax Telephone

I understand that this authorization is effective for 90 days from the date it is signed or _____ days, which ever is longer. I understand that I may revoke this authorization at any time except to the extent that actions have already been taken in reliance upon it, by giving notice to the Health Information Department. I understand that I have the right to inspect the information disclosed upon proper notification and under appropriate conditions established by Burgess Health Center.

Specific Authorization for Release of Information Protected by State or Federal Law

I specifically authorize the release of this Information as indicated by my initials OR if N/A

Type of Information to be Released	Initials of Patient or Legal Representative	Date
Alcohol/Drug Abuse Diagnosis/Treatment		
Mental Health Diagnosis/Treatment		
AIDS Related Diagnosis/Treatment/HIV Test Results		

Signature of Patient or Legally Authorized Representative

Relationship to Patient

Date of Authorization

Witness

Address if different than above

Second Witness for Verbal/Phone Auth.

This information has been disclosed to you from records whose confidentiality is protected by State laws. State law prohibits you from making further disclosure of the information without specific written consent of the person to whom the record pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose.