capitol hill medical

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# Authorization To Release Medical Records:

## PATIENT INFORMATION:

Name (print) _____ DOB _____ SSN _____

## INFORMATION TO BE RELEASED FROM:

Name of facility or provider _____

Address _____

## INFORMATION TO BE SENT TO:

Name of designated receipient _____

Address _____ City _____ State _____ Zip _____

## INFORMATION TO BE RELEASED: (please initial one)

_____ The most recent 2 years of pertinent information (chart notes, labs, x-rays and special tests)
_____ All medical records
_____ Specific information (please specify) :

## PURPOSE FOR WHICH THE DISCLOSURE IS BEING MADE: (please initial one)

_____ Attorney _____ Insurance _____ Doctor _____ Personal

## PATIENT AUTHORIZATION :

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

* EXCLUDE the following information from the records released (please initial)

_____ Drug / Alcohol abuse/treatment & diagnosis
_____ HIV/AIDS diagnosis/treatment/testing
_____ Sexually transmitted disease
_____ Mental illness or psychiatric diagnosis/treatment

## MY RIGHTS:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

Signature: _____ Date: _____
(Patient, guardian*, or Authorized representative*)

**This authorization will expire 90 days from the date signed**
**Possible copying fee required**

Email: _____