Authorization for Release of Medical Records

Patient Information

Patient Name: ____
Date of Birth: ____
Phone Number: ___
Email (optional): _____

Records to Be Released

I authorize the release of the following information (check all that apply):

- ☐ Treatment notes / SOAP notes
- ☐ Evaluation and assessment records
- ☐ Treatment plans and progress notes
- ☐ Billing and insurance records
- ☐ Appointment history
- ☐ Other: _____

Purpose of Release

The purpose of this release is (check all that apply):

- ☐ Continuation of care
- ☐ Coordination with another healthcare provider
- ☐ Insurance or billing purposes
- ☐ Legal or personal use
- ☐ Other: _____

Records May Be Released To

Name of Individual / Organization: _____
Address: _____
Phone: ___ **Fax:** ___
Email: _____

Records May Be Released From

Practice Name: _____
Address: _____
Phone: ___ ***Fax:*** _____

Authorization & Acknowledgment

I understand that: - This authorization is voluntary and I may revoke it in writing at any time, except to the extent action has already been taken. - The information disclosed may be subject to re-disclosure by the recipient and may no longer be protected under HIPAA. - Refusal to sign this authorization will not affect my ability to receive treatment.

This authorization will expire on: _____
(If left blank, this authorization will expire one year from the date signed.)

Signature

Patient or Legal Representative Signature: ____
Printed Name: _____
Relationship to Patient (if applicable): ____
Date: ____

This authorization complies with HIPAA privacy regulations.