

AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL RECORDS

I hereby authorize the physicians or employees of _____
to forward my medical records.

DURATION:

Authorization shall be effective immediately and remain in effect for one year.

REVOCATION: *Written revocation will be effective upon receipt*

SPECIFY RECORDS:

Check the box and initial which type of information to be disclosed:

____ **MEDICAL INFORMATION** ____ **PSYCHIATRIC NOTES**
____ **BEHAVIORAL /MENTAL HEALTH TREATMENT** ____ **ADD /ADHD**
____ **DRUG/ALCOHOL TREATMENT** ____ **HIV TEST RESULTS**

RELEASE MEDICAL RECORDS FROM:

Doctor/Clinic _____

Address: _____

CITY/STATE/ZIP: _____

TELEPHONE NUMBER: _____ **FAX NUMBER:** _____

FORWARD MEDICAL RECORDS TO:

Doctor/Clinic/Patient: _____

Address: _____

CITY/STATE/ZIP: _____

TELEPHONE NUMBER: _____ **FAX NUMBER:** _____

- Under Federal Regulations known as HIPAA, patients may be charged a copying fee. HealthCare Partners charges .60 cents per page for medical records forwarded to an attorney, insurance company, or for personal use. There will be no charge for records transferred to another physician.

Patient Name: _____ **Date of Birth:** _____

Patient Signature: _____ **Date:** _____
Parent/ Legal Guardian or Authorized Representative