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AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

This authorization must be written, dated and signed by the patient or by a person authorized by law to give this authorization.

I authorize _____ to release a copy of the medical information for
(NAME OF HOSPITAL/PROVIDER)

_____/_____/_____ to _____
(NAME OF PATIENT) (D.O.B.) (NAME AND ADDRESS OF RECIPIENT)

By initialing the spaces below, I specifically authorize the release of the following medical records, if such records exist.

- | | |
|--|--|
| <input type="checkbox"/> All hospital records (including nursing records and progress notes) | <input type="checkbox"/> Most recent five year history |
| <input type="checkbox"/> Transcribed hospital records | <input type="checkbox"/> Clinician office chart notes |
| <input type="checkbox"/> Medical records needed for continuity of care | <input type="checkbox"/> Dental records |
| <input type="checkbox"/> Laboratory reports | <input type="checkbox"/> Physical therapy records |
| <input type="checkbox"/> Pathology reports | <input type="checkbox"/> Billing statements |
| <input type="checkbox"/> Diagnostic imaging reports | <input type="checkbox"/> Other; |

Please send the entire medical record (all information) to the above named recipient. The recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record.

HIV/AIDS related records (Must be initialed to be included in other documents)

Mental health information (Must be initialed to be included in other documents)

Genetic testing information (Must be initialed to be included in other documents)

Drug/alcohol diagnosis, treatment or referral information as listed on back (Federal Registration 42 CFR Part 2, requires a description of how much and what kind of information is to be disclosed. Provide a specific description of information on reverse of this form)

This authorization is limited to the following treatment:

This authorization is limited to the following time period:

This authorization is limited to Worker's Compensation claim for injuries of:
_____ (date)

This authorization may be revoked at any time. The only exception is when action is has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 100 days from the date of signing or shall remain in effect for the period reasonably needed for the request.

(DATE)

(SIGNATURE OF PATIENT OR PERSON AUTHORIZED BY LAW)