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AUTHORIZATION FOR THE RELEASE OF INFORMATION

PATIENT NAME: ____

MEDICAL RECORD #: ___________________________________ DATE OF BIRTH: _______/________/________

I authorize ☐ Dr Gordon L Grado, MD ☐ Dr Franklin S Danziger, MD ☐ Dr Janet M Nettleton, MD ☐ Dr Michael D Sapozink, MD to:

- ☐ obtain information from my medical records from:
- ☐ release information from my medical records to:

NAME: ____ PHONE #: (_____) _________-__________

ADDRESS: ____

CITY / STATE / ZIP

Please provide the following information from my medical records:

- ☐ duplicate copy of my medical records
- ☐ ____

I hereby consent to the release of records pertaining to treatment/diagnosis of the following:

- ☐ confidential alcohol or drug abuse – related information
- ☐ confidential HIV – related information
- ☐ confidential mental health diagnosis/treatment information
- ☐ confidential communicable disease – related information
- ☐ except as follows: ____

The purpose of this request is for:

- ☐ further medical care
- ☐ legal
- ☐ insurance
- ☐ disability/workman's comp
- ☐ radiology (all films are the property of the clinic & must be returned with 30 days)
- ☐ other: ____

I understand that this authorization shall expire, without my express revocation, six (6) months from the date written below (sixty (60) days for the drug/alcohol treatment records). I understand that a photocopy of this authorization is considered acceptable in lieu of the original.

PATIENT SIGNATURE: ____ **DATE:** ______________________

or

LEGAL REPRESENTATIVE SIGNATURE: ____ **DATE:** ______________________

WITNESS SIGNATURE: ____ **DATE:** ______________________

INFORMATION PREPARED & RELEASED BY: ____ **DATE RELEASED:** __________________