Print Form

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's full name: _____ Date of birth: _____
Street address: _____ SSN: _____
City, State, Zip: _____ Home phone: _____
Work phone: _____ Cell phone: _____

At the request of the individual, I _____ do hereby authorize One Care Medical to release:

Dates of: _____

- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Progress Notes
- ☐ Operative Reports
- ☐ Pathology Reports
- ☐ Laboratory Reports
- ☐ Radiology Reports
- ☐ ECG/EEG/Cardiac Cath
- ☐ Emergency Reports
- ☐ All Records
- ☐ _____
- ☐ _____

○ I do ○ I do not

authorize release of information related to AIDS (Acquired Immunod Efficiency Syndrome) or HIV (Human Immunodeficiency Virus, psychiatric care, and/or psychological assessment and treatment for alcohol and/or drug abuse.

INFORMATION RELEASED TO:

_____
Name of Company/Agency/Facility/Person

Street Address: _____
City, State, Zip: _____
Telephone: _____

PURPOSE OF DISCLOSURE:

- ☐ Referral to Specialist
- ☐ Leaving Practice
- ☐ Personal
- ☐ Insurance
- ☐ Other: _____
- ☐ Legal Investigation
- ☐ Continuing Care
- ☐ Worker's Comp
- ☐ Disability

I hereby authorize disclosure of health information for the above named patient. I understand that I may cancel this request with written notification but that it will not affect any information release prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that they medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

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_____ _____
Signature of individual or guardian (if person is under 18 years of age) or Personal Representative of Patient's estate

Date