**DANVILLE FAMILY PRACTICE**

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# AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

(If under 18 years of age, parent or guardian must sign)

PATIENT'S NAME: _____

PATIENT'S ADDRESS:_____

DATE OF BIRTH: _____ SS#: _____

PHONE: _____

This is an authorization to release any information FROM my medical records

TO: NAME: _____

ADDRESS: _____

_____

INFORMATION REQUESTED:

| OUTPATIENT | INPATIENT |
|---|---|
| ___Clinic Notes | ___History & Physical |
| ___Laboratory Tests | ___Laboratory Tests |
| ___Radiology | ___Radiology |
| ___ALL RECORDS | ___ALL RECORDS |
| ___Other (specify) | ___Discharge Summary |
| _____ | ___Consultation |
| _____ | ___Other (specify) |
| _____ | _____ |
| _____ | _____ |

Purpose of Request: _____

*SPECIAL AUTHORIZATION (ALL THREE MUST BE INITIALED)*

( ) My diagnosis and/or treatment for alcoholism and/or drug abuse or dependence may be released to the recipient noted on the above consent.

( ) My diagnosis and/or treatment regarding my mental health/rehabilitation may be released to the recipient noted on the above consent.

( ) My diagnosis and/or treatment for HIV/AIDS may be released to the recipient noted on the above consent.

This release authorization is valid for three months after signature date below and that I may change this, in writing, at any time unless action has already been taken and records released,

Date: _____ Time: _____ Signed: _____

Date: _____ Time: _____ Witness: _____

(If patient is unable to give consent due to a physical condition or age, sign below.)

Date: _____ Time: _____ Signed: _____ Relationship:_____

REV 9/21 (signature of guardian)