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MEDICAL RECORD REQUEST

I, _____ HEREBY AUTHORIZE

_____

_____

TO RELEASE MY MEDICAL RECORDS TO:

DR: _____

PATIENT NAME: _____

SSN: _____-_____-_____ DOB: _____

INFORMATION AUTHORIZED TO BE RELEASED

__Complete Medical Record __Consultation __Radiology/Reports

__Discharge Summary __Pathology __Labs

__Operative Reports __EKG __History & Physical

__Other, Please specify: _____

1. **I understand that this consent may be revoked in writing at anytime. With the exception and to the extent that disclosure of information has already occurred prior to this receipt of revocation by the above named provider. If revocation is not received, authorization will be considered valid for a period of time not to exceed 1 year from the date of signing.**
2. **I understand that the information authorized for release may include record which indicate the presence of a communicable or venereal disease including, but not limited to, hepatitis, syphilis, gonorrhea and Acquired Immune Deficiency Syndrome as well as mental health information, and/or records concerning treatment for alcohol and/or drug abuse.**
3. **I understand that a photocopy of this authorization is to be considered valid as the original.**
4. **I understand that the information use or disclosed pursuant to this authorization may be subjected to redisclosure by the recipient and may no longer be protected by Federal Law.**

Signature_____ Date_____

Witness _____ Date_____