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Authorization for Disclosure of Health Information
(Autorización para utilizar o divulgar su Información de Salud)

1. I hereby authorize the disclosure of the following information from the health records of:
(Autorizo la divulgación de la siguiente información de los registros de salud de):

Patient's Name/(Nombre del Paciente): _____DOB/*(Fecha de nacimiento)*:_____

Address/*(Direccion)*:_____ Phone #: _____

_____

Covering the period(s) of health care from _____ to _____

2. This information will be disclosed

To:

_____
Name of Office/Guardian

_____
Address

_____
City State Zip

_____/_____
Phone # Fax #

From:

_____
Name of Office

_____
Address

_____
City State Zip

_____/_____
Phone # Fax #

For the purpose of _____

3. Information to be disclosed:

____ Complete Health Records
____ History & Physical Examination
____ Consultation Reports
____ X-ray Reports
____ Discharge Summary
____ Progress Notes
____ Laboratory Tests
____Other (Please Specify):_____

I understand that this will include information relating to (check if applicable):
____ Acquired Immunodeficiency Syndrome (AIDS)
____ Human Immunodeficiency Virus (HIV) infection
____ Behavioral health service/psychiatric care
____ Treatment for alcohol and/or drug abuse

4. I understand this authorization may be revoked in writing at any time except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition.

5. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Parent/Guardian Name: _____

Signature: _____ **Date:** _____

Relationship to Patient: _____

Signature of Witness: _____ Date: _____

******PLEASE SEE OTHER SIDE FOR MEDICAL RECORDS FEES*******

FEES FOR MEDICAL RECORDS

If you are requesting Medical Records please be advised that there will be a charge as follows.

Up to 25 pages- *$**15 Flat fee***

Pages 25 and over $0.10 per page

Medical Records transferred to another office – ***No Charge***

Medical records will not be released until fee is collected

Number of Pages	Fee	Amount Paid	Staff Initials