MEDICAL INFORMATION RELEASE

Last Name	First Name & MI	Social Security	Date of Birth
Address			

I _____, do hereby consent to and
Patient's name or guardian

authorize _____ to disclose to
Record's Custodian Name

_____, _____
Name of Covered Entity Attention To

at _____
Covered Entity's Address

for the purpose of _____
State Reason

information from within my medical records relating to my identity, diagnosis, prognosis, or treatment. However, I do not give permission for any other use or re-disclosure of this information. Date of the information to be copied: _____ to _____.
Start date End Date

The information to be released is:

- ❑ Face Sheet
- ❑ History & Physical
- ❑ Evaluation
- ❑ Progress Notes
- ❑ Consultation
- ❑ Laboratory Results
- ❑ Other (Please Specify): _____
- ❑ EXCEPTION: I do not give permission to release (please specify): _____
  _____

I also understand that this consent may be revoked by me at any time by submitting a written revocation notice, except to the extent that action has been I understand that my authorization will remain effective for a period of 90 days from date of discharge or date of my request. taken in reliance thereon, and that this consent will remain in force in order to effectuate the purposes for which it was given.

Responsible Party Signature	Relationship	Date