# AUTHORIZATION AND REQUEST FOR HOSPITAL AND MEDICAL RECORDS
## (HIPAA COMPLIANT FORM)

**PATIENT NAME:** **SS#:** **D/O/B:**

I hereby authorize

To release my health information to: _____
_____
_____

The information to be disclosed to and used by the above is for the following purpose: _____.

This authorization is limited to the following dates of treatment:

**FROM:** **TO: present**

Information to be disclosed:

| | | |
|---|---|---|
| ___EMERGENCY ROOM RECORD | ___CONSULTATIONS | __COMPLETE RECORD |
| ___HISTORY & PHYSICAL EXAM | ___ PROGRESS NOTES | __ ABSTRACT |
| ___OPERATIVE REPTS & PATHOLOGY | ___ LAB. X-RAYS & TESTS | __ BILLING INFO. |
| ___DISCHARGE SUMMARY | ___NURSES' NOTES | __ X-RAY FILMS |
| ___OTHER_____ | ___OTHER_____ | __ NARRATIVE REPORT |

**I understand that the information to be disclosed included my identity, diagnosis and treatment including ALCOHOL, DRUGS, GENETIC TESTING, BEHAVIORAL OR MENTAL HEALTH SERVICES, REPRODUCTIVE RIGHTS, SEXUALLY TRANSMITTED & INFECTIOUS DISEASES, AIDS and HIV information, as possible.**

It is my intent that the use of the information furnished is prohibited for any purpose other than stated above and that the recipient is prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose state above.

I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that this revocation will not apply to the extent that you have already taken action in reliance on this authorization. This authorization will automatically expire 120 days from the date of my signature, unless I otherwise specify that this authorization will terminate on the following date, or concurrently with the following even or condition:_____.

PATIENT SIGNATURE:_____ **Dated:**_____