

Authorization for Release of Information

Release To: (Who should we send records to)

Name: _____

Address: _____

City/State/Zip: _____

Phone Number: _____ Fax Number: _____

Medical Record (s) For: (Patient Name)

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number(s): (_____) _____ (_____) _____

Daytime

Evening

_____ Entire Medical Record(s)-Including any records in the file from other physicians
OR only the following:

_____ laboratory results _____ progress note(s) _____ operative report(s)

_____ history and physical(s) _____ discharge summary _____ diagnostic test result(s)

_____ x-ray report(s) _____ consultation report(s)

_____ other (Specify) _____

Date of Service: From: _____ To: _____

Date

Date

Reason for Request: _____

• I fully understand that my medical record information, in connection with the treatment date(s) stated above, may contain AIDS (Acquired Immune Deficiency Syndrome) or HIV (Human Immunodeficiency Virus), mental health, developmental disabilities, and/or substance abuse test results or information. The medical record information disclosed is protected under State and Federal law and this privileged and confidential information may be disclosed only on my authorization, except as expressly required as law.

• I understand that I have the right to inspect and copy information that is disclosed.

• I understand that if I refuse to consent to the release of information, my medical record information will not be released and denial of insurance reimbursement may occur.

I understand that I may withdraw this authorization at any time by submitting in writing a notice of revocation to Suburban Lung Associates except to the extent that action has already been taken.

Signature: _____ **Relationship:** _____ **Date:** _____

Age 17 or younger-parent/guardian needs to sign)

I authorize _____ to pick up my medical record information in the event of unforeseen circumstances.