Office Use Only
Date Received: _____
Account #: _____
Date Records: _____
Sent By: _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please read carefully before signing and dating.
All sections must be complete to be HIPAA compliant.

1 Patient Name: _____ **Birthdate:** _____
(PLEASE PRINT) MM/DD/YYYY

Have you ever used another name (maiden, adopted, nickname,etc)? ☐ yes _____
☐ no

Address: _____ **Phone #:** _____
STREET ADDRESS CITY STATE ZIP

2 INFORMATION TO BE RELEASED *FROM:*
INDICATE SPECIFIC CLINIC/PROVIDER

_____
CLINIC OR PROVIDER

_____
STREET ADDRESS

_____
CITY, STATE, ZIP

_____
PHONE FAX

INFORMATION TO BE RELEASED *TO:*
REQUEST MUST HAVE COMPLETE ADDRESS

_____
CLINIC OR PROVIDER

_____
STREET ADDRESS

_____
CITY, STATE, ZIP

_____
PHONE FAX

3 INFORMATION AUTHORIZED TO RELEASE

☐ All medical records/dates

☐ Medical records for the following dates: _____ (date) to _____ (date)

☐ Other (please specify information needed): _____

NOTE: Please allow up to 30 days to process this release.
Copying fees of $20 + $.50 per page may apply (personal and legal reasons)

4 PURPOSE: ☐ Personal ☐ Transfer of Care ☐ Continuation of Care ☐ Other: _____

5 REVOCATION & AUTHORIZATION

I understand that I have the right to revoke my authorization at any time by notifying the above-named provider of information, in writing, except when this authorization was obtained as a condition of obtaining insurance coverage. Any release of information made prior to my revocation in compliance with this authorization shall not constitute as a breach of my rights to confidentiality. Information used/disclosed pursuant to this authorization may be subject oto redisclosure by the recipient and no longer protected.

I understand that the information released from my health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) or gene related impairments, including genetic testing. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse or self-paid services. New Life Clinic is hereby authorized to release all information related to such diagnosis, testing, and treatment, unless specifically excluded below.

EXCLUSIONS: ☐ Drug/Alcohol abuse treatment & diagnosis ☐ HIV/AIDS/STD diagnosis, treatment & testing
☐ Behavioral and mental health records

6 PRINT PATIENT NAME: _____ **DATE:** _____

LEGAL SIGNATURE: _____ **RELATION TO PATIENT:** _____
(Parent/guardian signature if under age of 19) (if other than self)