
# Authorization to Release Health Information *(18 years and older)*

*Patients who are 18 years and older are considered legal adults and are required to sign for their own records. Signing this form will grant or limit the parent/legal guardian permission to have access to your medical records.*

***Please note that all billing information will be sent to the guarantor of your insurance policy.***

**Patient Information:**

Name of Patient: _____ Date of Birth: _____

Phone: _____

**At my request the following information may be released to my parent or guardian: (*please only pick one*)**

☐ **Entire record including ALL *labs*** *(This does not include correspondences from outside offices. Those records need to be obtained from that location)*

☐ **Specific visit including labs: _____ *(please list date of visit you are requesting)***

☐ DO NOT RELEASE RECORDS TO ANYONE OTHER THAN MYSELF

**Parent(s)/guardian(s) who may receive information:**

Name(s): _____

Address: _____ Phone: _____

**The above mentioned person(s) may receive my medical records in the following form (*please initial by each section that you approve*):**

_____ Receive records via phone. The practice may also leave voicemails for the phone number listed on this form

_____ Receive records by fax _____ Pick up physical documents at the front desk _____ Receive records by mail

***This authorization shall be in effect for one year from the date signed. After that time, a new signature will be required to release any records.***

**Patient Rights:**

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed, but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization. My treatment will not be conditioned on signing.

I understand that released information may include any communicable disease diagnoses as part of the record.

_____ _____

Signature of Patient Date