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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 (typically the parent) of your insurance policy.

Patient Name: _____ Date of Birth: _____

Phone Number:_____ Email:_____

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

_____ Entire record including ALL labs (This may include correspondences from outside offices). Those records may need to be obtained from your previous medical provider.)

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

_____ DO NOT RELEASE RECORDS TO ANYONE OTHER THAN MYSELF

Parent(s) / Guardians who may receive my medical records:

Name: _____ Phone Number: _____
Address: _____ Email: _____

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

_____ Receive Results by 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 WILL EXPIRE TWELVE (12) MONTHS FROM THE DATE SIGNED.

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 because 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 diagnosis as art of the record

_____ _____
Signature of Patient Date