**Patient First**

MEDICAL RECORD #: _____-_____
Center # - Patient #

# Authorization for Release of Information

PATIENT NAME: _____ _____ _____ _____
LAST FIRST MI MAIDEN OR OTHER NAME

DATE OF BIRTH: _____-_____-_____ LAST 4 DIGITS OF SS#: _____
MO DAY YR

**I hereby authorize** Patient First **or** _____ **(Print Name of Provider) to release my medical record and/or items checked below to:**

NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

**INFORMATION TO BE RELEASED:** Date(s):

- ❑ Medical Record _____
- ❑ X-rays _____
- ❑ EKG _____
- ❑ Itemized Statement _____
- ❑ Other: _____ _____

**PURPOSE OF DISCLOSURE:** ❑ Changing physicians ❑ Consultation/second opinion ❑ Insurance
❑ Continuing Care ❑ Legal ❑ School
❑ Workers Compensation ❑ At my request (You are not required to give a reason.)
❑ Other (please specify): _____

- I understand that if Patient First has requested this authorization, then I will get a copy of this form after I have signed it.
- I understand that this authorization will be valid for one year.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
- I understand that information disclosed to the above individual or organization may be redisclosed and not protected by the Federal privacy regulations.
- I understand that my right to receive medical services from Patient First will not be affected if I refuse to sign this authorization.
- I understand that if my record contains information related to substance abuse, HIV related information and/or mental health information, that information will be released with my medical record.

_____ _____
Signature of Patient/Legal Guardian/Personal Representative Date

_____
If signed by anyone other than the patient, state the relationship and/or reason and legal authority to do so.