



Medical Record Release

I hereby authorize:

To disclose to:

Name of disclosing party

Name of recipient

Address

Address

City State Zip

City State Zip

RECORDS AND INFORMATION FOR THE PAST TWO (2) YEARS PERTAINING TO:

Patient name (list other names used)

SSN

Date of Birth

Address

Phone number

Duration: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here _____ (date).

Revocation: This authorization is subject to written revocation by the patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

Re-disclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

- Medical information _____ (initials)
- Psychiatric information _____
Signature _____ Date _____
- Drug/Alcohol Information _____
Signature _____ Date _____
- Results of HIV Test _____
Signature _____ Date _____
- Genetic Records _____
Signature _____ Date _____
- Other Health Information _____ (initials and specify below)
- Specify the records to be disclosed: _____

This authorization does / does not discontinue my care through AllCare Medical Group.

The recipient may use the health information authorized on this form for the following purposes:

Signature Date If signed by other than patient, indicate relationship

(A copy of this authorization is as valid as the original. Patient has a right of receive a copy of this authorization.)



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