**Authorization to Release Healthcare Information**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security: ###-##-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I request and authorize my healthcare information to be:

**Release to:**  **Release from:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INFORMATION TO BE PROVIDED** (check one or more):

All Medical Records/Information

Abstract

Billing records

Outpatient Record

Diagnostic Test/Results

History & Physical

Discharge Summary

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do not include: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Unless indicated above, I acknowledge that this request specifically includes medical, psychological, psychiatric, developmental-alcohol and/or drug abuse, human immunodeficiency virus (HIV) testing and treatment, AIDS related information, and genetic information if in the possession of MAXHealth (“MAXHealth”).

***Please include date(s) of service from***: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (records will be provided for all service dates if left blank)

**FORMAT**

I request that the copy be provided (where possible/available):

On paper  In an electronic format  Discuss my medical information only  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If requesting an unencrypted format, by signing below you acknowledge that you understand the inherent risks involved with sending and receiving information in an unencrypted, unsecured, format (such as regular email or unencrypted disc). Such risks include misdirected messages, email intrusion, interception, or views by unauthorized parties. I understand there may be a fee for a copy of my health information. All fees will be in compliance with applicable law.

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

THIS AUTHORIZATION EXPIRES WHEN THE PATIENT IS

NO LONGER UNDER THE CARE OF THE FACILITY REFERENCED ABOVE