AUTHORIZATION FOR REQUEST OF MEDICAL RECORD INFORMATION

PATIENT NAME:____

ADDRESS:____

DATE OF BIRTH:________________ **SOCIAL SECURITY #:**________________

I hereby request and authorize:

____
Name of healthcare facility

____
Address

____
City State Zip

____
Phone Fax

To release to:

____
Name of person or facility requesting information

____
Address

____
City State Zip

____
Phone Fax

The foregoing is subject to such limitations as indicated below:

( ) 1. Confined to records regarding admission and treatment for the following medical condition:

____

( ) 2. Covering records for the period from _________________ to _________________

( ) 3. Confined to the following specific information:_______________________________

( ) 4. NO LIMITATIONS PLACED ON DATES, HISTORY OR ILLNESS, OR DIAGNOSTIC AND THERAPEUTIC INFORMATION, INCLUDING ANY TREATMENT FOR ALCOHOL AND DRUG ABUSE AS PROTECTED BY FEDERAL REGULATION 42CFR, PART II, PSYCHIATRIC/ PSYCHOLOGICAAL INFORMATION AND AIDS RELATED INFORMATION, INCLUDING TESTING, FS 490.32 AND/OR 90.503, 381.609

This authorization shall expire thirty (30) days from the date signed.

______________________________ ______________ ____________________
Signature Date Relationship

______________________________ ______________
Witness Date