Authorization for release of medical information for continuity of care

proactive md

Patient Name: _____ Date of Birth: _____

Patient Address: _____ SS#: _____

_____ Phone: _____

The undersigned hereby authorizes _____ **to release**

information contained in my medical records to: _____

Covering records for the period from: _____ to _____
Date Date

Specific information to be disclosed: _____

_____

This authorization places no restrictions on any information to be released, including any treatment for alcohol, drug abuse, HIV testing, or psychiatric conditions. If any restrictions are to be placed on the information released, please state:

_____

_____

The patient is voluntarily signing this authorization. The patient reserves the right to refuse to sign this authorization. The patient is entitled to review or receive a copy of the information for which the authorization is being sought. The patient reserves the right to revoke this authorization at any time. This revocation must be in writing. information may be subject to redisclosure by the recipient and no longer protected.

_____

Signature of Patient Date Signature of Parent/Guardian Date

_____

Signature of Personal Representative Date Description of Right to Act for the Individual

_____

Witness Date Identification

Expiration of this authorization is one (1) year from date of signature, unless otherwise specified. ANY DISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENT(S) IS PROHIBITED EXCEPT WHEN IMPLICIT IN THE PURPOSES DISCLOSURE.